S. HRG. 110–583

IMPROVEMENTS IMPLEMENTED AND PLANNED BY THE DEPARTMENT OF DEFENSE AND THE DEPARTMENT OF VETERANS AFFAIRS FOR THE CARE, MANAGEMENT, AND TRANSITION OF WOUNDED AND ILL SERVICEMEMBERS

HEARING

BEFORE THE

COMMITTEE ON ARMED SERVICES
UNITED STATES SENATE

ONE HUNDRED TENTH CONGRESS

SECOND SESSION

FEBRUARY 13, 2008

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WEDNESDAY, FEBRUARY 13, 2008

U.S. SENATE,
COMMITTEE ON ARMED SERVICES,
Washington, DC.

The committee met, pursuant to notice, at 9:32 a.m. in room SD–106, Dirksen Senate Office Building, Senator Carl Levin (chairman) presiding.

Committee members present: Senators Levin, Kennedy, Bill Nelson, E. Benjamin Nelson, Webb, Warner, Inhofe, Sessions, Chambliss, Dole, Thune, and Wicker.

Committee staff members present: Richard D. DeBobes, staff director; and Leah C. Brewer, nominations and hearings clerk.

Majority staff members present: Gabriella Eisen, counsel; Gerald J. Leeling, counsel; and Peter K. Levine, general counsel.

Minority staff members present: Michael V. Kostiw, Republican staff director; William M. Caniano, professional staff member; David G. Collins, research assistant; Lucian L. Niemeyer, professional staff member; Diana G. Tabler, professional staff member; and Richard F. Walsh, minority counsel.

Staff assistants present: Fletcher L. Cork, Jessica L. Kingston, Ali Z. Pasha, and Brian F. Sebold.

Committee members' assistants present: Bethany Bassett and Jay Maroney, assistants to Senator Kennedy; James Tuite, assistant to Senator Byrd; Bonni Berge, assistant to Senator Akaka; Christopher Caple, assistant to Senator Bill Nelson; Andrew R. Vanlandingham, assistant to Senator Ben Nelson; Jon Davey, assistant to Senator Bayh; M. Bradford Foley, assistant to Senator Pryor; Gordon I. Peterson, assistant to Senator Webb; Jennifer Cave and Sandra Luff, assistants to Senator Warner; Anthony J. Lazarski and Nathan Reese, assistants to Senator Inhofe; Lenwood Landrum and Todd Stiefler, assistants to Senator Sessions; Mark J. Winter, assistant to Senator Collins; Clyde A. Taylor IV, assistant to Senator Chambliss; Adam G. Brake, assistant to Senator Graham; Lindsey Neas, assistant to Senator Dole; Jason Van Beek, assistant to Senator Thune; and Erskine W. Wells III, assistant to Senator Wicker.

OPENING STATEMENT OF SENATOR CARL LEVIN, CHAIRMAN

Chairman LEVIN. Good morning, everybody. The committee meets this morning to review actions taken over the last year to improve living conditions, outpatient care, and processes to help our severely injured and ill servicemembers as they transition to care provided by the Department of Veterans Affairs (VA) into civilian life and to discuss actions in progress or yet to commence.

Our witnesses this morning were scheduled to be: Deputy Secretary of Defense Gordon England—and before I identify the other witnesses, let me say that I understand that Secretary Gates had a fall last night on the ice and broke his shoulder and therefore now he must be represented by Gordon England at another hearing that Secretary Gates was supposed to be at himself. Is that correct?

Secretary GEREN. Yes, sir, that's correct.

Chairman LEVIN. It's our hope that you would express to Secretary Gates our, first of all, hopes for a very speedy and prompt recovery. We obviously want him back in action. We understand totally, of course, why the Secretary cannot be with us this morning.

Our other witnesses are: Deputy Secretary of Veterans Affairs Gordon Mansfield; Secretary of the Army Pete Geren; Under Secretary of Defense for Personnel and Readiness David Chu; and the Surgeon General of the Army, Lieutenant General Eric Schoomaker.

We understand Admiral Dunne is here with you, Secretary Mansfield, this morning. We welcome you, of course, as well, Admiral.

Our Nation has a moral obligation to provide quality health care to the men and women who put on our Nation's uniform and are injured and wounded fighting our Nation's wars. On February 18, 2007, the headlines of the Washington Post read "Soldiers Face Neglect, Frustration at Army's Top Medical Facility." A series of articles by Dana Priest and Ann Hull served as a wakeup call regarding the care and treatment of our wounded warriors. The articles that appeared in the press a year ago described deplorable living conditions for servicemembers living in outpatient status at Walter Reed, a bungled bureaucratic process for assigning disability ratings that determined whether a servicemember would be medically retired with health and other benefits for the member and for his family. They described a clumsy handoff from the Department of Defense (DOD) to the VA as these injured soldiers try to move on with their lives. We also learned that these problems were not limited to the Army or to Walter Reed.

A lot has been accomplished in the wake of these articles and much more needs to be done. This committee held a hearing on March 6, 2007, to address the shortfalls in the care of our wounded warriors. At that hearing we concluded that it would require the coordinated efforts of the VA Committee and the Armed Services Committee to address the issues in a comprehensive manner.

This led to a rare joint hearing of the Committee on Armed Services and the Committee on Veterans Affairs on April 12. The committees continued to work together to pass the Dignified Treatment of Wounded Warriors Act on July 25, 2007. This comprehensive bipartisan legislation that addressed the care and management of

our wounded warriors was drafted, marked up, and passed by the Senate in record time.

This act, enhanced by provisions in the House-passed Wounded Warrior Assistance Act of 2007, became the Wounded Warrior Act that was included in the recently signed National Defense Authorization Act for Fiscal Year 2008. The Wounded Warrior Act represents major reform and was supported by veterans service organizations. It advances the care, management, and transition of recovering servicemembers; enhances health care and benefits for families; and begins the process of fundamental reform to the disability evaluation systems of DOD and the VA.

We require the DOD in this law to use VA standards for rating disabilities and to use the VA presumption of sound condition in determining whether a disability is service-connected. We increase the disability severance pay for certain servicemembers. We required the DOD and the VA to jointly develop a comprehensive policy on improvements to care and management of recovering servicemembers. We established centers of excellence for traumatic brain injury (TBI), post-traumatic stress disorder (PTSD), and traumatic eye injuries, and we authorized respite care for seriously injured servicemembers.

The Wounded Warrior Act addresses nearly all the findings of the various commissions that have examined the issues regarding the care and treatment of our wounded warriors. The most significant exception is the recommendation of the Dole-Shalala Commission to restructure the VA disability compensation system. The essence of that recommendation is a restructuring of the VA disability compensation benefit. It falls, the recommendation, primarily in the jurisdiction of the House and Senate Veterans Affairs Committees, both of whom are examining it.

The VA has just recently awarded a contract to develop information regarding changes in the composition of disability payments, as recommended by the Dole-Shalala Commission, and some veterans service organizations have already expressed some questions about this change.

Working together in an approach that is consistent with the Wounded Warrior Act, the Departments of Defense and Veterans Affairs established a high-level senior oversight committee, cochaired by the Deputy Secretary of Defense and the Deputy Secretary of Veterans Affairs, to oversee analysis of and changes to the DOD and VA systems, to improve the care and treatment of our injured and ill servicemembers. We hope to learn this morning what the Departments have accomplished thus far, what initiatives are in the works, and if any additional legislation is needed to accomplish their goals.

The Army has established the Army medical action plan (AMAP) to develop a sustainable system for the medical treatment and rehabilitation of injured and ill soldiers, to prepare them for successful return to duty or transition to civilian status. I'm confident that Secretary Geren and General Schoomaker will have more to say about that.

Finally, we are proud of the fact that our military doctors, nurses, and medics have courageously provided outstanding medical care to those who are wounded. This care begins on the battle-

field itself, where these providers are at great personal risk as they tend to the wounded. Many servicemembers who would have died in earlier conflicts are surviving injuries incurred in Iraq and Afghanistan because of the loving care and the advances in battlefield medical treatment that exist now, that didn't exist before, but also, and we want to reiterate this, because of the skill and the bravery of our combat medical teams.

Seriously injured troops are rapidly evacuated to world-class medical facilities, where they receive state-of-the-art care as inpatients.

Today's hearing is about the actions taken by the Departments of Defense and Veterans Affairs and by the Army to implement the Wounded Warrior Act and recommendations made by various commissions over the many months.

I'd like to add that although Senator Lieberman is not here with us today, he has requested that his statement be entered into the record, and without objection, it will be.

[The prepared statement of Senator Lieberman follows:]

PREPARED STATEMENT BY SENATOR JOSEPH I. LIEBERMAN

Chairman Levin, thank you for convening this important hearing on the status of our wounded warriors.

Almost a year ago, we learned from press reports that many of our recovering servicemembers at Walter Reed Army Medical Center were not receiving adequate medical services or were living in unacceptable conditions. Along with many of my colleagues, I promised to fix these problems and improve the quality of care given to those who have served honorably. I am heartened that this committee and many others in Congress stood up and fulfilled their moral responsibility by including Wounded Warrior legislation in last year's National Defense Authorization bill. We have made significant improvements, but we still have more challenges to solve.

In the coming weeks, I plan to introduce legislation to address two pressing problems. My first proposal will increase and improve incentives for the recruitment and retention of uniformed mental health providers. One in six Operation Iraqi Freedom/Operation Enduring Freedom servicemembers has a diagnosable condition of post-traumatic stress disorder. However, if we do not have enough uniformed providers in place, we will not have the manpower to treat all servicemembers who need help. The need for uniformed providers cannot be overemphasized in light of their dual missions to not only deploy to combat zones, but staff garrison military treatment facilities across the globe. Uniformed mental health professionals are also critical because those returning from combat strongly prefer to receive care from a fellow servicemember. As we learn more about the mental health conditions that arise from repeated tours of duty, we must have the uniformed workforce in place to meet the demands of our returning servicemembers and the long-term challenges facing the Department to improve both the access to and the quality of mental health care.

My second piece of legislation focuses on suicide prevention in the military. Our military's most valuable resource is the people who serve our country in uniform. In the past year, there have been a number of disturbing reports in the news concerning the Army's suicide rate, which was higher in 2007 than any other time this statistic has been tracked by the military, and significantly higher than in the civilian population. We must reverse the current trend. My legislation will create a new prevention program, modeled on the Air Force's highly successful aircraft accident prevention program, at the Department of Defense to investigate all suicides. An independent body, assembled by a four-star general, would produce a confidential report, including recommendations to address any recognized deficiencies. We must have the protocols in place to make sure we are able to determine when a servicemember needs help or immediate attention, and I believe my proposal will go a long way in preserving our most valuable resource—our men and women in uniform.

We can all agree that taking care of our wounded warriors must remain a national priority. Many obvious deficiencies have been corrected, and now I call upon my colleagues to tackle the remaining challenges before us. We have asked our servicemembers to accept near-impossible trials and tribulations on the battlefield.

The least we can do is to provide them with the best possible care and the attention they deserve.

Chairman LEVIN. There is a vote scheduled for 10:30 this morning. I hope that we can complete our opening statements and begin questions even before the vote.

Senator Warner.

STATEMENT OF SENATOR JOHN WARNER

Senator WARNER. Thank you, Mr. Chairman.

Mr. Chairman, this is a most unique piece of legislation, and one of its hallmarks is the strong bipartisan effort that's been put in on both sides of the aisle, and one of the stalwarts on our side, Senator Sessions, has been at the forefront of this. I'm going to invite him now to deliver the remarks for our side of the aisle.

Senator Sessions.

Senator SESSIONS. Thank you, Senator Warner. I do care about this deeply, as I know you do, and thank you for your leadership and that of Senator Levin.

I welcome our panel members. It's a distinguished group and I think your appearance here today represents by your very positions the commitment the DOD has to fixing the problems that we've seen. Images of a mold-infested room at Walter Reed, which was home to a recovering servicemember will not and should not be forgotten. We're all accountable for the conditions at Walter Reed and its impact on families. We're all answerable to the American people for the full and complete resolution of those problems.

There's just no doubt that when we commit our men and women to harm's way if they are injured, there is a deep bond we have with them, I think, that cannot be disputed, that we will do whatever we can to assure they have the finest medical care possible.

The independent review group established by Secretary Gates in February 2007 described the situation that overwhelmed Walter Reed as a "perfect storm." It involved the confluence of an increase in operational tempo as a result of the war, the decision of the commission on BRAC to close Walter Reed, inattention by leaders to processing delays, and antiquated disability evaluation processes, a breakdown in outpatient care and transition to the VA. In addition, the DOD lacked the tools to adequately identify TBI and its overlap with PTSD.

We now realize that the problems were far broader than just the Walter Reed site, and I believe that progress in addressing shortfalls in care is underway. Congress provided $900 million in supplemental funding to DOD in fiscal year 2007 for the purpose of aiding wounded and ill servicemembers with TBI and PTSD. The Army has activated a new Warrior Transition Brigade focused solely on helping wounded and ill soldiers to heal. As of February 4, 2008, 9,782 soldiers, both Active and Reserve, are assigned or attached to a warrior transition unit (WTU).

The Army now has broken ground on a new and greatly expanded hospital at Fort Belvoir, VA, which will be completed ahead of the BRAC schedule and will improve services for our wounded and ill military personnel, especially for orthopedic and mental health concerns. I know Senator Warner is very proud of that hospital that will be at Fort Belvoir.

It is evident by our panel today that the DOD and the VA are working together, rather than at odds. Yet, according to the DOD's recent survey of wounded and ill servicemembers, one in four rate "poorly" for their experience with the medical evaluation board process. One in five rates "poorly" for their ability to access care and appointments as soon as needed.

Studies conducted in the last year reassure the American people that the men and women who volunteer for our military and are sent into harm's way will receive the best medical care in the world. I quote from the report of the Gates panel, which said: "Through advances in battlefield medicine and evacuation care the Department has achieved the lowest mortality rates of wounded in history."

I quote also from the report of the commission appointed by President Bush, co-chaired by Senator Robert Dole and Secretary Donna Shalala: "The medical care at Walter Reed Army Medical Center and other military treatment facilities (MTFs) is compassionate and complete. The specialized services and programs for amputations and burns in particular are world class."

So this hearing will examine the response of our government to the shortfalls for servicemembers who are outpatients during the long-term healing they require. The Wounded Warrior Act is itself a significant contribution toward that goal. I was privileged to be a part of that significant bipartisan effort, along with many members of this committee and the Veterans Committee.

The new law will ensure cooperation between the DOD and VA, open new avenues of treatment for TBI and psychological health, and begin the process of reforming the disability evaluation system for our Nation's veterans of war, in other words achieving nearly all the goals of the Dole-Shalala Commission. So we look to the Committee on Veterans Affairs for leadership on the important work which remains—modernization of the benefits and compensation for our Nation's veterans, and in particular eliminating duplication between DOD and VA.

Senator Burr, the ranking member of that committee, has announced his intention to pursue the needed reforms through legislation to create a modern, less confusing and more equitable system for today's wounded warriors. We shall forget neither the images of Walter Reed nor the stories of so many wounded veterans and their families who, as a result of a lack of care and perceived lack of fairness, lost trust in the government that they served. Nor shall we ever forget the statement of General George Washington, who said: "The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive the veterans of earlier wars were treated and appreciated by their country."

Mr. Chairman, thank you, and I look forward to this excellent panel today.

Chairman LEVIN. Thank you, Senator Sessions.

Let me start with Secretary Mansfield and then we'll go to you, Secretary Chu. Are you going to be giving the statement for Secretary England?

Dr. CHU. Yes, sir, I'll give Secretary England's prepared remarks.

Chairman LEVIN. Thank you.

Secretary Mansfield?

STATEMENT OF HON. GORDON H. MANSFIELD, DEPUTY SECRETARY OF VETERANS AFFAIRS; ACCOMPANIED BY HON. PATRICK W. DUNNE, REAR ADMIRAL, U.S. NAVY (RETIRED), ASSISTANT SECRETARY OF VETERANS AFFAIRS FOR POLICY AND PLANNING

Secretary MANSFIELD. Thank you, Chairman Levin and members of the committee. I appreciate the opportunity to appear before you today. I'm especially pleased to be accompanied by Admiral Dunne, Secretary Geren, Secretary Chu, and General Schoomaker.

The VA and the DOD have a positive, good news report to give you today on our enhanced partnership to ensure today's Active Duty servicemembers and veterans receive the benefits, care, and services a grateful Nation has promised them. They have surely earned that and I know, Mr. Chairman and members, that you and the committee members are here to make sure that it happens.

I'm especially pleased to have had the opportunity to have worked with Gordon England, the Deputy Secretary of the DOD. Over the past year Gordon and I have had a unique opportunity to focus the attention of both Departments on the needs of those we serve, our servicemembers and veterans. We have concentrated attention on the need for a seamless transition from the DOD to the VA.

I want to publicly thank him for his leadership, which has allowed us to accomplish so much. As he has said, the ties between the two organizations have been strengthened and lines of communication are now available across the two Departments.

The Senior Oversight Council (SOC) has been operational since May 8, 2007, but it is important to note that serious high-level cooperative efforts in the areas of health care and benefits delivery predate the SOC. VA and DOD formed a Joint Executive Council (JEC) in February 2002. You later codified it in statute in November 2003. The JEC's responsibility—and I quote from its standup document—is "The JEC will work to remove barriers and challenges, assert and support mutually beneficial opportunities, recommend to the two secretaries the strategic directives for joint coordination and sharing efforts between and within the two Departments, and oversee the implementation of those efforts."

I believe it is important to identify some of the positives produced under the auspices of the JEC from its start. Dental care for Reserve and National Guardsmen was taken care of—the North Chicago VA and U.S. Navy cooperative effort to form the first joint Federal health care facility non-sequitar; and the Traumatic Servicemembers' Group Life Insurance which has been effective thanks to Congress since December 1, 2005. As of January 31, we have paid 4,111 claims for a total of $254.4 million to seriously injured servicemembers.

We now have more than 95 memoranda of understanding (MOUs) covering 153 military sites; VBA counselors inserted at MTFs; data-sharing efforts; and the joint incentive fund that Congress authorized to fund 66 projects for $160 million between the two organizations.

So in short, the JEC provided a starting point for the SOC. I want to commend and thank Dr. David Chu for his past and continued efforts and cooperation as my DOD partner on the JEC.

The SOC, established by direction of the two secretaries following, as you mentioned, Mr. Chairman, hearings here on the Hill, established eight lines of action, which generally defined the issues needing resolution. They include: the disability evaluation system; TBI and PTSD case management; data-sharing efforts; facilities; legislation and public affairs; personnel, pay, and financial support; and what we call a clean sheet review, or after we've looked at all these issues, if you were starting over how would you start and what would you build that would be different from what we have today.

Our excellent joint DOD and VA staff, provided through a special office by Melinda Darby and Roger Dimsdale, identified these lines of action from the issues presented in numerous reports, investigations, or commissions which reported last year, as you mentioned, Mr. Chairman—Dole-Shalala, Gerry Scott's commission, the Marsh-West commission, and Secretary Nicholson's commission that the President directed that he take part in. All were reviewed completely to come up with a comprehensive plan of action.

Currently the SOC is overseeing the efforts to apply the decisions made from these line of action recommendations. For example, the Federal recovery coordinators or case managers' decision has resulted in VA Federal recovery coordinators standing up an office, hiring the first eight individuals, training them, placing them in MTFs, and having them start the process of fulfilling that requirement which you directed for us.

In another area, we have started a pilot project to have the VA complete one single medical exam, which will allow first DOD under their responsibility to make the decision whether this individual is fit or unfit to continue to serve on Active Duty, and if the individual is not fit to serve on Active Duty to allow the VA to use that same information to process a claim for disability benefits when the individual is discharged. This pilot has gotten one case already through the process. The examinations are taking place in the Washington, DC, area and the cases are going to the VA office in St. Petersburg for decision. This pilot will run for approximately 1 year starting last November, going to November this year, and will give us the starting point for more efforts on how to make sure that this transfer from Active Duty to veteran status becomes seamless and the information is transferred and used by both at the same time.

We realize we have more work to do, data-sharing for example, where we move to the ability to transfer patient data between our two systems. We're doing more than we ever had before. We're sharing data. We're moving toward making it operational, and I think I can report to you that more efforts are going forward in that area than ever before. It's a hard area. There are a lot of issues to deal with, and we continue to work on that at a high level.

We're also working together on TBI and PTSD issues—care, research, and treatment, as we see a greater emphasis on these

issues, and a new center of excellence is under construction and will be taking place at the new Bethesda location.

Currently the SOC is prepared to come together whenever required to make decisions required by the dedicated VA and DOD staff which oversee the efforts on each of these lines of action. We continue to address any issues which may arise regarding cooperation between the two Departments. Gordon England, David Chu, and I continue to discuss these issues as needed. The remaining requirements stemming from the National Defense Authorization Act passed last session will keep us focused intently on continuing improvements.

The issue of a new disability benefit system as proposed by the President through the Dole-Shalala report remains an open item. The VA has contracted for two studies which will allow us to move forward in this area. The studies are due for completion in approximately 6 months. They deal with transition payment and then compensation and quality of life issues in a to-be-proposed system.

The issue of rehabilitation medicine continues to evolve as we treat and evaluate the patients returning from the battlefield, entering acute care treatment, and initial rehabilitation and MTFs before they transition to VA polytrauma centers and medical centers.

Finally, we are working to ensure better involvement and care of the family members of these individuals.

That concludes my statement and I await your questions.

[The joint prepared statement of Secretary England and Secretary Mansfield follows:]

JOINT PREPARED STATEMENT BY HON. GORDON ENGLAND AND HON. GORDON MANSFIELD

Chairman Levin, Senator McCain, and members of the Senate Committee on Armed Services, we deeply appreciate your steadfast support of our military and welcome the opportunity to appear here today to discuss improvements implemented and planned for the care, management, and transition of wounded, ill, and injured servicemembers. We are pleased to report that while much work remains to be completed, meaningful progress has been made.

We're delighted to have with us Secretary of the Army Geren, Under Secretary of Defense for Personnel and Readiness Chu, Surgeon General of the Army, Lieutenant General Schoomaker, and Assistant Secretary of Veterans Affairs for Policy and Planning Dunne.

The administration has worked diligently—commissioning independent review groups, task forces, and a Presidential Commission to assess the situation and make recommendations. Central to our efforts, a close partnership between our respective Departments was established, punctuated by formation of the Senior Oversight Committee (SOC) to identify immediate corrective actions and to review and implement recommendations of the external reviews. The SOC continues work to streamline, deconflict, and expedite the two Departments' efforts to improve support of wounded, ill, and injured servicemembers' recovery, rehabilitation, and reintegration.

Specifically, we have endeavored to improve the Disability Evaluation System (DES), established a Center of Excellence for Psychological Health and Traumatic Brain Injury, established the Federal Recovery Coordination Program, improved data sharing between the Department of Defense (DOD) and Department of Veterans Affairs (VA), developed medical facility inspection standards, and improved delivery of pay and benefits.

SENIOR OVERSIGHT COMMITTEE

The driving principle guiding SOC efforts is the establishment of a world-class seamless continuum that is efficient and effective in meeting the needs of our wounded, ill, and injured servicemembers, veterans, and their families. The body is

composed of senior DOD and VA representatives and co-chaired by the Deputy Secretary of Defense and Deputy Secretary of Veterans Affairs. Its members include: the Service Secretaries, the Chairman or Vice Chairman of the Joint Chiefs of Staff, the Service Chiefs or Vice Chiefs, the Under Secretaries of Defense for Personnel and Readiness and Comptroller, the Under Secretaries of Veterans Affairs for Benefits and Health, the Office of the Secretary of Defense General Counsel, the Assistant Secretary of Defense for Health Affairs, the Director of Administration and Management, the Principal Deputy Under Secretary of Defense for Personnel and Readiness, the Assistant Secretary of Veterans Affairs for Policy and Planning, the Deputy Under Secretary of Defense for Plans, and the Veterans Affairs Deputy Chief Information Officer. In short, the SOC brings together on a regular basis the most senior decisionmakers to ensure wholly informed, timely action. Supporting the SOC decision-making process is an Overarching Integrated Product Team (OIPT), co-chaired by the Principal Deputy Under Secretary of Defense for Personnel and Readiness and the Department of Veterans Affairs Under Secretary for Benefits and composed of senior officials from both DOD and VA. The OIPT reports to the SOC and coordinates, integrates, and synchronizes work and makes recommendations regarding resource decisions.

MAJOR INITIATIVES AND IMPROVEMENTS

The two Departments are in the process of implementing more than 400 recommendations of 5 major studies, as well as implementing the Wounded Warrior and Veterans titles of the recently enacted National Defense Authorization Act (NDAA), Public Law No. 110–181. We continue to implement recommended changes through the use of policy and existing authorities. For example, in August 2007, the Secretaries of the Military Departments were directed to use all existing authorities to recruit and retain military and civilian personnel who care for our seriously injured warriors. Described below are the major initiatives now underway.

DISABILITY EVALUATION SYSTEM

The fundamental goal is to improve the continuum of care from the point-of-injury to community reintegration. To that end, in November of last year, a DES Pilot test was implemented for disability cases originating at the three major military treatment facilities in the National Capital Region (Walter Reed Army Medical Center, National Naval Medical Center Bethesda, and Malcolm Grow Medical Center). The pilot is a servicemember-centric initiative designed to eliminate the often confusing elements of the two current disability processes of our Departments. Key features include both a single medical examination and single source disability rating. A primary goal is to reduce by half the time required to transition a member to veteran status and receipt of VA benefits and compensation.

The pilot addresses those recommendations that could be implemented without legislative change from the reports of the Task Force on Returning Global War on Terror Heroes, the Independent Review Group, the President's Commission on Care for America's Returning Wounded Warriors (Dole/Shalala Commission), the Veterans Disability Benefits Commission (Scott Commission), and the DOD Task Force on Mental Health. Its specific objectives are to improve timeliness, effectiveness, transparency, and resource utilization by integrating DOD and VA processes, eliminating duplication, and improving case management practices.

To ensure a seamless transition of our wounded, ill, or injured from the care, benefits, and services of DOD to the VA system, the pilot is testing enhanced case management methods and identifying opportunities to improve the flow of information and identification of additional resources to the servicemember and family. The VA is poised to provide benefits and compensation to the veterans participating in the pilot as soon as they transition from the military.

The pilot covers all non-clinical care and administrative activities, such as case management and counseling requirements associated with disability case processing, from the point of servicemember referral to a Military Department Medical Evaluation Board (MEB) through compensation and provision of benefits to veterans by the VA. Expansion of the pilot is being considered to address:

- Performance measures—The pilot evaluation plan includes extensive quantitative and qualitative performance measures to ensure our servicemembers obtain all benefits and entitlements due under both DOD and VA law. Although no servicemembers have completely transitioned from the pilot to veteran status, we expect a reasonable sample population to have processed through by mid-June. We'll complete our initial analysis at that time and make a determination regarding expanding the pilot.

- Site assessment—The following criteria will be thoroughly analyzed by both Departments: resources, IT architecture development and fielding, case management effectiveness, training requirements, DES workload (for DOD and VA) in expansion areas, and costs;
- Case management—Most importantly, pilot expansion to a broader population will require training and certification of DES and VA administrative and case management personnel. It is anticipated that certification of the case managers and determination of the appropriate case manager staff size will be the overriding factors that limit or allow expansion of the pilot to other areas.
- Phased expansion—Unlike the pilot's Physical Evaluation Board phases, which are consolidated in the NCR, the medical assessment and MEB phases occur across the departments at numerous Medical Treatment Facilities (MTFs) and Veterans Health Administration sites. Phased expansion of the pilot should allow MTF site preparation and training on a manageable timeline.

The pilot is part of a larger effort including medical research into the signature injuries of the war and updating the VA Schedule of Rating Disabilities. Proposed regulations to update the disability schedule for traumatic brain injury (TBI) and burns were published in the Federal Register on January 3, 2008.

PSYCHOLOGICAL HEALTH AND TRAUMATIC BRAIN INJURY

Improvements have been made in addressing issues concerning psychological health (PH) and TBI. The focus of these efforts has been to create and ensure a comprehensive, effective, and individually-focused program dedicated to prevention, protection, identification, diagnosis, treatment, recovery, and rehabilitation for our servicemembers, veterans, and families who deal with these important health conditions.

The DOD has a broad range of programs designed to sustain the health and well-being of every service and family member in the total military community. Because no two individuals are exactly alike, multiple avenues of care are open to create a broad safety net that meets the preferences of the individual. This continuum of care encompasses: prevention and community support services; early intervention to protect and restore before chronicity, and before the member does something rash; service-specific deployment-related preventive and clinical care before, during and after deployment; sustained, high-quality, readily available clinical care along with specialized rehabilitative care for severe injuries or chronic illness, and transition of care for veterans to and from the VA system of care; and a strong foundation of epidemiological, clinical and field research.

Our Departments have partnered in the development of standard clinical practice guidelines for Post-Traumatic Stress Disorder (PTSD), Major Depressive Disorder, Acute Psychosis, and Substance Use Disorders. These guidelines help practitioners determine the best available and most appropriate care for PH conditions. In an effort to ensure that providers are trained in best practices, we are partnering in providing training in evidence-based treatment for PTSD.

TBI can result in decreased reaction time, impaired decisionmaking and judgment, and decreased mental processing. Mild TBI or concussion can reduce mission effectiveness and increase risk to the injured servicemember and others in the unit. Objective cognitive performance information can give the commander critical information for informed risk decisions in mission planning and execution while providing medical providers with an objective assessment of the extent of the injury and a method of tracking recovery. To facilitate the evaluation and management of TBI cases, DOD has a program to collect baseline neurocognitive information on Active and Reserve personnel before their deployment to combat theaters. The Army already has incorporated neurocognitive assessments as a regular part of its Soldier Readiness Processing in select locations. Additionally, select Air Force units are assessed in Kuwait before going into Iraq.

To ensure all servicemembers are screened appropriately for TBI, questions have been added to Post-Deployment Health Assessment and Post-Deployment Health Reassessment. That same information is shared with VA clinicians as part of an effort to facilitate the continuity of care for the veteran or servicemember.

To ensure appropriate staffing levels for PH, a comprehensive staffing plan for PH services has been developed based on a risk-adjusted, population-based model. To augment staffing levels, DOD has partnered with the Department of Health and Human Services (HHS) to provide uniformed Public Health Service officers in MTFs to increase available mental health providers for DOD. DOD and the VA also con-

tinue to improve the Mental Health Self Assessment Program. Program expansions, documented in an updated report to Congress submitted in February 2007, included:

- Addition of telephone-based screening for those who do not have access to the Internet including a direct referral to Military OneSource for individuals identified at significant risk;
- Availability of locally tailored, installation level referral sources via the online screening;
- Introduction of the evidence-based Suicide Prevention Program for Department of Defense Education Activity schools to ensure education of children and parents of children who are affected by their sponsor's deployment; and
- Addition of a Spanish language version for all screening tools, expanded educational materials, and integration with the newly developed pilot program on web-based self-paced care for PTSD and depression.

In November 2007, the Department of Defense Center of Excellence (DCoE) for Psychological Health and Traumatic Brain Injury was established as a national Center of Excellence for PH and TBI. It includes VA and HHS liaisons, as well as an external advisory panel organized under the Defense Health Board, to provide the best advisors across the country to the military health system. The center facilitates coordination and collaboration for PH and TBI related services among the military Services and VA, promoting and informing best practice development, research, education, and training. The DCoE is designed to lead clinical efforts toward developing excellence in practice standards, training, outreach, and direct care for our military community with PH and TBI concerns. It also serves as a nexus for research planning and monitoring the research in this important area of knowledge. Functionally, the DCoE is engaged in several focus areas, including:

- Mounting an anti-stigma campaign (the Army's Mental Health Advisory Team 5 survey shows that stigma and fears of seeking help are being reduced, but there is more to do);
- Establishing effective outreach and educational initiatives;
- Promulgating a tele-health network for clinical care, monitoring, support and follow-up;
- Coordinating an overarching program of research including all DOD assets, academia and industry, focusing on near-term advances in protection, prevention, diagnosis, and treatment;
- Providing training programs aimed at providers, line leaders, families, and community leaders; and
- Designing and planning for the National Intrepid Center of Excellence (anticipated completion in fall 2009), a building that will be located on the Bethesda campus adjacent to the new Walter Reed National Military Medical Center.

The fiscal year 2007 supplemental appropriation provided DOD $900 million in additional funds to make improvements to our PH and TBI systems of care and research. These funds are important to support, expand, improve, and transform our system and are being used to leverage change through optimal planning and execution. The funds have been allocated and distributed in three phases to the Services for execution based on an overall strategic plan created by representatives from DOD and the Services with VA input. Of the $600 million operation and maintenance funds, $566 million (94 percent) has been distributed, including $315 million for PH and $251 million for TBI. The remaining balance is reserved for expansion of promising demonstration programs and for additional costs that emerge as the plans are executed.

CARE MANAGEMENT

To improve care management, the complexities between our two care management systems are being reduced through the Federal Recovery Coordination Program, which will identify and integrate care and services for the wounded, ill, and injured servicemember, veteran and their families through recovery, rehabilitation, and community reintegration.

New comprehensive practices for better care, management, and transition are being implemented. These efforts include responses to requirements of the NDAA 2008 regarding the improvements to care, management, and transition of recovering servicemembers. Progress is being made toward an integrated continuity of quality care and service delivery with inter-Service, interagency, intergovernmental, public and private collaboration for care, management and transition, and the associated training, tracking, and accountability for this care. Our efforts include important re-

forms such as uniform training for medical and non-medical care/case managers and recovery coordinators, and a single tracking system and a comprehensive recovery plan for the seriously injured.

The joint FRCP trains and deploys Federal Recovery Coordinators (FRCs) to support medical and non-medical care/case managers in the care, management, and transitioning of seriously wounded, ill, and injured servicemembers, veterans and their families. The FRCP will develop and implement web-based tools, including a Federal Individual Recovery Plan (FIRP) and a National Resource Directory for all care providers and the general public to identify and deliver the full range of medical and non-medical services. To date, the Departments have:

- Hired, trained, and placed eight FRCs at three of our busiest MTFs as recommended by the Dole/Shalala Commission. Additional FRCs will be hired as needed beginning in May;
- Developed a prototype of the FIRP as recommended by the Dole/Shalala Commission; and
- Produced educational/informational materials for FRCs, Multi-Disciplinary Teams, and servicemembers, veterans, families, and caregivers.

We are also in the process of:

- Developing a prototype of the National Resource Directory in partnership with Federal, State, and local governments and the private/voluntary sector, with public launch this summer;
- Producing a Family Handbook in partnership with relevant DOD/VA offices;
- Identifying workloads and waiver procedures for medical case/care managers, non-medical care managers, and FRCs; and
- Developing demonstration projects with States such as California for the seamless reintegration of veterans into local communities.

DATA SHARING BETWEEN DEPARTMENTS OF DEFENSE AND VETERANS AFFAIRS

Steps have been taken to improve the sharing of medical information between our Departments to develop a seamless health information system. Our long-term goal is to ensure appropriate beneficiary and medical information is visible, accessible, and understandable through secure and interoperable information technology. The SOC has approved initiatives to ensure health and administrative data are made available and are viewable by both agencies. DOD and the VA are securely sharing more electronic health information than at any time in the past. In addition to the outpatient prescription data, outpatient and inpatient laboratory and radiology reports, and allergy information, access to provider/clinical notes, problem lists, and theater health data have recently been added. In December 2007, DOD began making inpatient discharge summary data from Landstuhl Regional Medical Center immediately available to VA facilities. The plan for information technology support of a recovery plan for use by FRCs was approved in November 2007. A single web portal to support the needs of wounded, ill, or injured servicemembers, commonly referred to as the eBenefits Web Portal, is planned based on the VA's successful eVet website.

MEDICAL FACILITIES INSPECTION STANDARDS

Progress has been made to ensure our wounded warriors are properly housed in appropriate facilities. Using the comprehensive Inspection Standards, all 475 military MTFs were inspected and found to be in compliance although deferred maintenance and upgrades were cited. The Services are continuing an aggressive inspection of MTFs on an annual basis to ensure continued compliance, identify maintenance requirements, and sustain a world-class environment for medical care. In the event a deficiency is identified, the commander of the facility will submit to the Secretary of the Military Department a detailed plan to correct the deficiency, and the commander will periodically reinspect the facility until the deficiency is corrected.

All housing units for our wounded warriors have also been inspected and determined to meet applicable quality standards. The Services recognize that existing temporary medical hold housing is an interim solution and have submitted fiscal year 2008 military construction budgets to start building appropriate housing complexes adjacent to MTFs. They will also implement periodic and comprehensive follow-up programs using surveys, interviews, focus groups, and town-hall meetings to learn how to improve housing and related amenities and services.

TRANSITION ISSUES/PAY AND BENEFITS

Servicemembers transitioning from military to civilian life can also benefit from a collaborative effort between DOD and the Department of Labor (DoL). The DoL Pre-Separation Guide, which informs servicemembers and their families of available transition assistance services and benefits, is now available at http://www.TurboTAP.org.

Another resource tool for transitioning servicemembers is the expanded Small Business Administration's Patriot Express Loan program. The Patriot Express Loan offers a lower interest rate and an accelerated processing time. Loans are available for up to $500,000 and can be used by wounded warriors for most business purposes. DOD has also expanded Wounded Warrior Pay Entitlement information on the Defense Finance and Accounting Service (DFAS) website and other organizations have linked to the website; in July 2007, the DFAS posted an easily understood decision matrix on eligibility for Combat-Related Injury Rehabilitation Pay (CIP) which allows wounded warriors to determine their eligibility for CIP on the website. Additionally, through use of streamlined debt management procedures, DFAS remitted, canceled, or waived debts for over 14,126 wounded warrior accounts totaling approximately $13.17 million as of January 29, 2008.

DOD and the VA have shared information concerning Traumatic Injury Servicemembers Group Life Insurance (TSGLI) and implemented plans replicating best practices. The Army is now placing subject-matter experts at MTFs to provide direct support of the TSGLI application process and improve processing time and TSGLI payment rates. The VA Insurance provider's payment time, upon receipt of a certified claim from the branch of Service, averages between 2 and 4 days. DOD has been successful using congressional authority from the NDAA allowing continuation of deployment related pays for those recovering in the hospital after injury or illness in the combat zone. This ensures no reduction in deployment pays while the servicemember is recovering.

We are creating a compensation/benefits website and handbook that will help servicemembers and veterans make informed decisions about their futures. The VA has just commissioned two studies to implement the recommendations of the Dole/Shalala Commission. The first study will evaluate the levels and duration of transition benefit payments to assist veterans and their families while they are in a vocational rehabilitation program. The second study will develop recommendations for creating a schedule for rating veterans' disabilities based upon current concepts of medicine and disability, taking into account the loss of quality of life and loss of earnings resulting from service-connected disabilities. Results of the study will to be provided to the VA by August 2008.

CONCLUSION

The SOC and its Overarching Integrated Product Team continue to work diligently to resolve the many outstanding issues while aggressively implementing the recommendations of Dole/Shalala, the NDAA, and the various aforementioned task forces and commissions. These efforts will expand in the future to include the recommendations of the DOD Inspector General's report on DOD/VA Interagency Care Transition, which is due shortly.

One of the most significant recommendations from the task forces and commissions is the shift in the fundamental responsibilities of the DOD and VA. The core recommendation of the Dole/Shalala Commission centers on the concept of taking the DOD out of the disability rating business so that DOD can focus on the fit or unfit determination, streamlining the transition from servicemember to veteran.

While we are pleased with the quality of effort and progress made, we fully understand that there is much more to do. We also believe that the greatest improvement to the long-term care and support of America's wounded warriors and veterans will come from enactment of the provisions recommended by Dole/Shalala. We have, thus, positioned ourselves to implement these provisions and continue our progress in providing world-class support to our warriors and veterans while allowing our two Departments to focus on our respective core missions. Our dedicated, selfless servicemembers, veterans, and their families deserve the very best, and we pledge to give our very best during their recovery, rehabilitation, and return to the society they defend.

Chairman Levin, Senator McCain, and members of the committee, thank you again for your generous support of our wounded, ill, and injured servicemembers, veterans and their families. We look forward to your questions.

Chairman LEVIN. Thank you, Secretary Mansfield.

Secretary Chu?

STATEMENT OF HON. DAVID S.C. CHU, UNDER SECRETARY OF DEFENSE FOR PERSONNEL AND READINESS

Dr. CHU. Mr. Chairman, I thank you for the opportunity to represent the DOD this morning. Again I convey Secretary England's apologies that he could not be here. He very much looked forward to this session and asked that I present his planned opening remarks. He does have a statement for the record which I hope you will accept.

Chairman LEVIN. We will.

Dr. CHU. It is indeed a great privilege to join Gordon Mansfield, who has been our strong partner in the SOC that he described and in the JEC established earlier. The two Departments have worked very closely, as he has outlined, and strengthened thereby the ties between the two Cabinet agencies so that we can indeed provide veterans the support that they deserve.

Gordon Mansfield has summarized the lines of action, the eight lines of action that are the mechanism through which the SOC exercises its responsibilities. These lines of action are jointly staffed, co-chaired by personnel from DOD and the VA, and have created a very strong partnership between the two agencies. They have succeeded in accomplishing a great deal in a short period of time. We have, as Gordon Mansfield reported, appointed the first Federal response coordinators. We have the disability evaluation pilot underway and 120 people are in various stages of evaluation in that pilot system. We have established the Center for Psychological Health and Traumatic Brain Injury. We are, I believe, on track to completing by the end of this year a set of software changes that will allow existing electronic data to be shared between the two agencies, which I know has long been a subject of great concern to all.

We have proposed to Congress and we hope Congress will support an accelerated and enhanced set of changes at the new Walter Reed campus in Bethesda, where the Naval Hospital is currently located.

We have benefited in these decisions from the studies that were done earlier and, of course, from the actions of Congress. In the earlier studies there are over 400 recommendations offered to the Department, over 300 on the subjects of PTSD and TBI alone.

While a great deal has been done, we recognize that we are not finished. These lines of actions will be adding to their agendas, particularly with the additional instruction of Congress in the National Defense Authorization Act for Fiscal Year 2008. We meet as necessary to accomplish these goals.

Secretary England asked that I underscore that he and Gordon Mansfield and their respective teams are completely dedicated to resolving all the issues between the two Departments and to putting the long-term care of the men and women in uniform where it should be. We view this as a partnership between the two Departments and a partnership with Congress, the caregivers within our Departments, and with other agencies of the Federal Government, as well as agencies at the State and local level.

Secretary England did ask that I underscore one other issue which you raised, Mr. Chairman, and Secretary Mansfield touched on in his opening statement. That is, we do hope Congress, in fu-

ture legislation, will address a central issue raised in the Dole-Shalala proposal, and that is a new and different disability compensation system for our veterans, one that would more sharply delineate the responsibilities of the respective Departments, focusing DOD on the key military question of fitness to serve and focusing the VA on the question of support for those who cannot.

I am joined this morning by Secretary Geren and General Schoomaker, who will be ready to provide details on the progress the Army has made in its specific efforts to care for the Army's wounded personnel.

Thank you for this opportunity and I look forward to your questions.

Chairman LEVIN. Thank you, Secretary Chu.

Secretary Geren?

STATEMENT OF HON. PRESTON M. GEREN III, SECRETARY OF THE ARMY

Secretary GEREN. Thank you, Mr. Chairman. Chairman Levin, Senator Warner, and members of the committee: Thank you for providing General Schoomaker and I the opportunity to come before your committee today and talk about the progress that has been made over the past year. I'd also like to thank every one of you for your unwavering support of soldiers, families, and our United States Army. Our Congress and particularly this committee are full partners in building the Army that we have today.

I also want to thank you for your Wounded Warrior Act and the initiatives, which you included in last year's authorization bill. You included initiatives that will help soldiers; initiatives that will help families; and you also provided the flexibility so that the Army could continue to meet the dynamic challenges in our modern health care world, and we appreciate that. We thank you for that partnership in your legislation and the partnership over this last year.

Twelve months ago almost to the day, the Washington Post ran their story on the shameful conditions at Walter Reed. The report sparked outrage across our Nation, but nowhere more so than among the ranks of soldiers and veterans, nowhere equal to the outrage, the rage felt by soldiers. Soldiers take care of soldiers. Soldiers give their lives and limbs for each other. Strip away everything else and at its core that is what the Army is all about: Soldiers taking care of soldiers.

When soldiers learned that some of their own had violated their duty to our wounded, they demanded action and stepped up and took action. Today, 12 months later, we are a better Army, with good news to report to this committee, because of the good work and hard work of soldiers, but with the acknowledgment that there remains much to do.

Mr. Chairman, I'd like to ask you if I could introduce four of the soldiers who have been great leaders in this effort over the past year who have joined us today.

Chairman LEVIN. We'd be honored to have you do that.

Secretary GEREN. Thank you, Mr. Chairman.

Colonel Terry McKendrick, who is Brigade Commander at Walter Reed—Terry, would you please stand up—his Command Sergeant

Major Jeff Hartless; Company Commander Major Steve Gominter; and his First Sergeant, Matthew Dewsberry. They've done an outstanding job and deserve a great deal of credit for their leadership. [Applause.]

Chairman LEVIN. Thank you, Secretary Geren, for introducing to us these great soldiers. Again, we're honored to be in their presence.

Secretary GEREN. Thank you, Mr. Chairman.

The Army, the DOD, and the VA, and Congress' response has gone well beyond the problems identified in the Washington Post series of articles. We all realized that we had an opportunity not to just fix the problems highlighted in the articles, but transform our health care and disability system to better meet the needs of those who have borne the battle—our wounded, ill, and injured, and better support their families.

It is an opportunity to do something big, complicated, and important that does not come along very often, and together we've made progress, and we thank you for that partnership.

Today Lieutenant General Schoomaker and I will discuss the progress the Army has made and join this panel in discussing the progress the DOD has made working with Congress and particularly with this committee, and identify areas that we must continue to improve.

A year ago, outpatient care in the Army was called medical hold for Active Duty and medical holdover for Reserve components. The names themselves, "hold" and "holdover," and the fact that there were two systems give you a good sense of the problems that underlay the Army system. A year later, the Army has completely transformed outpatient care. The old system, with fragmented leadership, that was not staffed, resourced, nor organized to meet even the pre-September 11 needs of outpatient soldiers, was overwhelmed by the increase in patients that came with the casualties of war. Preexisting seams were stretched and snapped by the surge in wounded, ill, and injured. The Guard and Reserve were organized separately from the Active Force, with a widely held perception, if not the reality, of different standards of care. Mental health issues had not received the attention nor the resources they required, leaving the needs of many soldiers and family members unmet.

Today, there are no more hold or holdover units. In their place, we have our wounded warriors in 35 WTUs located at major posts in CONUS and abroad, Active, Guard, and Reserve together, one Army.

The care and support of our soldiers in our WTUs is driven by a mission statement, with leadership, officer and NCO, organized in support of that mission, with a triad of care, the squad leader, the nurse case manager, and the primary care manager, supporting every wounded, injured, and ill soldier.

Our soldiers in the WTUs are being moved into the best barracks on the post and over the last 8 months nearly 2,500 personnel have been added to Medical Command to support our wounded warriors. Every WTU today has an ombudsman and now 33 and soon all of our WTUs will have a Soldier Family Assistance Center, bringing

dispersed family services together into a one-stop shop for soldiers and families.

In mental health care, the Army, working with our sister Services, OSD, and the VA, and with strong leadership and support from Congress, has made investments in personnel, infrastructure, and programs to care for soldiers who suffer from TBI, PTSD, and other mental and emotional illnesses, and help their families with the challenges of supporting their soldiers suffering from these invisible wounds of war, with much left to do in this area.

In the Army, we're teaching every one of our one million soldiers how to identify symptoms of PTSD and TBI and how and where to go to get help. Every soldier is required to take that class. So far, 800,000 soldiers have received the training, and the program is available to families. It is good substantive training, but, perhaps more importantly, it is a major step forward in reducing the stigma associated with mental health care.

We're seeking to hire over 300 additional mental health professionals to meet the needs of soldiers and families, adults and children. We are short of this goal and face a challenging market for the people we need. The direct hire authority that you provided to us in your authorization bill is a big help, but we're not where we need to be in this area. We've initiated a comprehensive approach to prevent the tragedy of suicide among our soldiers, recognizing we have far to go to stem this growing challenge among our ranks, much to learn and much to do.

Cooperation between the DOD, OSD, and our sister Services and the VA is strong and you will hear today about much of the progress that's been made.

Senator Levin and Senator Sessions, thank you for acknowledging the extraordinary work of our Army's health care professionals. They are selfless men and women who are the very best at what they do.

In stark contrast to the shortcomings identified in the Post article are the almost miraculous recent advances in battlefield medicine, trauma care, and rehabilitation, much of which has been accomplished by the medical professionals and staff at Walter Reed and elsewhere in the Army system. Survival rates for soldiers wounded in combat are unprecedented, 94 percent, the highest in the history of warfare. Soldiers are surviving and recovering from wounds that would have been fatal in any other era and in any other health care system, thanks to the service men and women in military medicine, the Army, and our sister Services.

Throughout the Army, we have leaders, officers, and NCOs, uniformed and civilian, committed to taking care of soldiers and families, demanding the best for our wounded, ill, and injured and their families. Because of that, our report today is one of progress, but it is not and probably never will be a report of mission accomplished.

February 18, 2007, was a day our Army will not forget, a painful day, a shameful day for a proud institution, a band of brothers and sisters who look out for each other, who take care of each other, no matter the personal cost. The Washington Post helped us see something that we had overlooked and because of that Washington Post story we are a better Army today than we were a year ago,

and we remain committed to continuing to improve our care and support of our wounded, our ill, and our injured soldiers and our families.

Mr. Chairman, members of the committee, thank you all for the opportunity to appear today. I look forward to answering your questions.

[The prepared statement of Secretary Geren follows:]

PREPARED STATEMENT BY HON. PETE GEREN

Chairman Levin, Senator McCain, and distinguished members of the Senate Armed Services Committee, I want to thank you for inviting LTG Eric Schoomaker and me to appear before you today. We are pleased to have the opportunity to discuss with you how we are transforming the way we care for our wounded, ill, and injured warriors.

I'd also like to thank all of you for your unwavering support of our soldiers and families. I know they appreciate your ongoing efforts to provide them with the ways and means to accomplish their mission and to improve their quality of life. Congress has been a valued partner in creating the remarkable Army we have today. Thank you for the initiatives you included in National Defense Authorization Act (NDAA) 2008 to improve health care for our wounded, ill, and injured soldiers.

The problems identified by the Washington Post were centered in our medical hold and medical holdover populations, the outpatient care of our wounded, ill, and injured soldiers—they experienced poor facilities, leadership challenges, and an entrenched bureaucracy; however, the improvements we will discuss today go well beyond addressing the shortcomings identified in those articles.

In stark contrast to the shortcomings identified in the Washington Post are the phenomenal advances in lifesaving battlefield medicine and overall trauma care, much of which has been accomplished through the efforts of the extraordinary medical professionals at Walter Reed. Survival rates for soldiers wounded in combat are unprecedented. In the Vietnam War, it took 21 days to evacuate a soldier from theater. In Iraq we routinely evacuate a soldier within 36 hours. Improvements such as the Joint Theater Trauma System, state-of-the-art evacuation system, improved body armor and battlefield equipment such as the one-handed tourniquet mean that, today, more than 90 percent of those wounded in Iraq and Afghanistan survive, making this the highest survival rate in the history of warfare. We have the best medical specialists, doctors, and nurses in the history of the Army, and many non-medical soldiers are skilled emergency medical technicians or combat lifesavers.

The soldier outpatients at Walter Reed who were highlighted in the Washington Post were housed in inadequate facilities, experienced a failure of leadership, and were caught in an unresponsive bureaucracy. The Physical Disability Evaluation System (PDES) was cumbersome and did not allow this increasing number of patients to efficiently move through the system. This put a burden on Walter Reed that it was not prepared to handle.

As an Army, we pledge never to leave a fallen comrade—that means on the battlefield, in the hospital, in the outpatient clinic, or over a lifetime of dependency. We broke that pledge, and we have paid a price for that. I am pleased to report, however, that the Army has made and continues to make significant improvements in the areas of infrastructure, leadership, and processes as part of our Army Medical Action Plan (AMAP).

First, wounded, ill, and injured soldiers—Active, Guard, and Reserve—have been organized into 35 military units under the command and control of the medical treatment facility commander. The new Warrior Transition Units (WTUs) focus solely on the care of their soldiers. All 35 of our WTUs are now at full operational capability.

Second, we've given the soldiers in the WTUs a mission that is codified in the Wounded Warrior Mission Statement:

> "I am a Warrior in Transition. My job is to heal as I transition back to duty or become a productive, responsible citizen in society."

This is not a status, but a mission.

> "I will succeed in this mission because I am a warrior."

Third, every soldier in the WTUs is supported by a triad of care, a primary care manager who is a physican, a nurse case manager, and a squad leader.

We've assigned 1 squad leader for every 12 soldiers, 1 primary care manager for every 200 soldiers, and 1 nurse case manager for every 18 or 36 soldiers depending

on the medical complexity of the unit. Each unit also has a dedicated ombudsman who reaches out to soldiers and families as an extra resource and problem-solver.

Fourth, we've established Soldier and Family Assistance Centers (SFACs) at medical centers and treatment facilities across the Army to replace the old system that had family services scattered across multiple locations. These are "one-stop shops" where soldiers and families can get information and help with services from help with entitlements, to benefits, to finances.

Fifth, we created a 24/7 hotline that provides Warriors in Transition and their families 24-hour access to information and assistance. The Army has responded to over 7,000 calls on the hotline.

Sixth, we created a new leadership position for warrior care, the Assistant Surgeon General for Warrior Care and Transition, currently held by BG Mike Tucker. He is our designated "bureaucracy buster." His role is to facilitate immediate and sustained assistance to our wounded, ill, and injured soldiers and their families. Under BG Tucker's leadership, and with the active assistance of many other soldiers, leaders, and Army civilians, we have made substantial progress in cutting the red tape. Some of the many substantive changes we have made since February 2007 include:

- Continuing Combat-Related Injury Pay while soldiers are assigned to the WTU or Community-Based Health Care Organization.
- Created a special duty pay for our WTU noncommissioned leaders (squad leaders and platoon sergeants).
- Preference for wounded soldiers for their location of care within constraints of facility capabilities.
- Providing wounded soldiers top priority in housing.
- Authorized Permanent Changes of Station for Warrior in Transition families.
- Reduced paper work for Army PDES processing.
- Expanded the 14-day window to 90 days for a soldiers to transition to the Department of Veterans Affairs (VA) after disability determination by the Army.
- Provided free internet, phone, and cable TV to WTU barracks.
- Colocated VA Advisors at Army hospitals and facilities.
- Expanded VA access to Army soldier medical records.

We are developing Comprehensive Care Plans for each soldier in the WTU that set the conditions for the soldiers to achieve a successful return to duty or a successful transition to civilian life. We have worked with the National Rehabilitation Hospital on this effort to leverage best practices from the private sector.

We've initiated a Post Traumatic Stress Disorder (PTSD) and Traumatic Brain Injury (TBI) education program for every soldier in the Army. This program is designed to not only educate and assist soldiers in recognizing, preventing, and treating these conditions, but also to erase the stigma associated with these injuries. We also provide similar training to family members. Over 800,000 soldiers have received training since August 2007. We have also completed specialized PTSD/TBI training for social work personnel, nurse case managers, and psychiatric nurse practitioners.

To assist with the identification of TBI, we have initiated a baseline cognitive testing program. So far, 40,000 soldiers were tested predeployment. By July 2008, every soldier will receive a baseline test before deployment.

An experimental helmet sensor has been developed that will record impacts to the head. Over 1,145 of these helmet sensors are in use in theater today.

Behavioral health care is a critical area of emphasis for Army leaders at every level. I would like to highlight a number of mental health initiatives. We are:

- Hiring over 300 new mental health hiring actions, even in the face of national shortages of health care providers.
- Expanding the "Battlemind" training program that educates soldiers and families about deployment-related behavioral health concerns.
- Providing access to confidential mental health counseling for soldiers and their family members.

I also want to highlight the U.S. Army Wounded Warrior (AW2) Program, which assists and advocates for severely wounded, ill, or injured soldiers and their families throughout their lifetimes, wherever they are located. AW2 currently serves more than 2,300 soldiers, 600 on active duty, and 1,700 veterans. AW2 Program caseworkers work with soldiers and their families to proactively address and mitigate issues they encounter in their recovery. AW2 provides unique services to the most severely disabled including:

- Helping wounded soldiers remain in the Army by educating them on their options and assisting them in the application process.
- Assisting soldiers with future career plans and employment opportunities beyond their Army careers.
- Supporting soldiers and families with a staff of subject matter experts proficient in non-medical benefits for wounded soldiers.

Finally, we have improved the ways we "listen" to the needs of our wounded soldiers and their families and monitor the quality of care and support we provide to our soldiers. We are using third party-surveys and input from more than 18 internal and external sources.

Our surveys show that soldiers and their families continue to have questions about the PDES, but they have seen improvements in soldiers' assessment of the care and leadership provided by the WTUs.

We will continue to fine-tune feedback mechanisms that provide us with multiple perspectives from which to see ourselves. Examples of those things we measure are:

- Access to care
- Appointment "no show" rate
- "Leader to led" ratios
- Satisfaction survey results
- Medical Evaluation Board (MEB) processing timeliness
- Awards
- Uniform Code of Military Justice actions
- Status of cadre training
- Living conditions

General Casey and I also recently directed the Surgeon General to establish a Tiger Team to examine the soldier deaths that have occurred in WTUs. The Tiger Team presented an interim report this week and will continue to work to address this issue.

We are working to reform the current PDES. We have reduced the amount of paperwork soldiers are required to complete. The assignment of additional Staff Judge Advocates to provide legal advice to soldiers undergoing the PDES process has reduced formal Disability Evaluation board requests. We have also instituted standardized training and certification for the Physical Evaluation Board Liaison Officers that support our soldiers.

We have provided soldiers and their families interactive access to their MEB and Physical Evaluation Board (PEB), eliminating the need for appointments to review the paperwork and reducing the uncertainty that can plague the process. MEB and PEB review can now be done via secure Internet on Army Knowledge Online. We have increased the MEB staff so that staff-to-case ratios have dropped from 1:80 to a more effective 1:30 ratio. Finally, we are working with DOD on a PDES pilot study currently ongoing at Walter Reed.

The events of the last year have led to a strengthened partnership between the DOD and the VA. The senior leaders of both departments meet regularly as part of the Senior Oversight Committee (SOC). We are working together to provide a seamless transition for our soldiers from the DOD disability system either back to service in the Army or to a productive life as a veteran.

The SOC has directed the following:

- Establish a single, comprehensive, standardized medical exam for all wounded soldiers;
- Update the VA rating disabilities schedule to include TBI; and
- Establish a TBI/PTSD Center of Excellence.

In close coordination with the VA, the Army has executed the following actions:

- Added 16 VA liaison officers at major medical treatment facilities,
- Provided VA access to DOD medical records and databases as needed,
- Instituted a Federal Recovery Coordinator at Walter Reed and Brooke Army Medical Centers (a SOC initiative),
- Exchanged senior leaders with the VA, and
- Entered into an agreement with the VA governing coordination between VA benefits advisors and personnel at Army installations.

CONCLUSION

President Lincoln pledged our Nation to care for those who shall have borne the battle, their widows,—and now, widowers—and orphans. Working together, we must maintain that pledge not with words, but with deeds.

Before I close I want to note that two brigades' worth of wounded, ill, and injured soldiers are returning to the force every year. Greater than 65 percent of all wound-

ed, injured, or ill soldiers return to duty. About 27,000 of our soldiers have returned to the force since 2001, and 88 percent of these soldiers are noncommissioned officers, the backbone of your Army.

I want to thank the committee for supporting the improvements that we have been able to make under the AMAP and for the flexibility built into the recently passed NDAA. The provisions you carried forward from the Dignified Treatment of Wounded Warriors Act will help soldiers in critical areas such as TBI/PTSD treatment and research, expanded mental health care, and DOD/VA disability reform. Working together, we have made significant progress but several steps remain incomplete. The Army's ability to process wounded warriors would be improved if it were allowed to focus on fitness for duty and let the VA focus on disability determination and compensation. This is a key and critical provision of the Dole/Shalala recommendations.

Again, thank you for inviting me to testify. I look forward to your questions.

Chairman LEVIN. Thank you, Secretary Geren. That was a very important statement and a very moving statement. Thank you for the preparation of it and for delivering it the way you did.

General Schoomaker?

STATEMENT OF LTG ERIC B. SCHOOMAKER, USA, SURGEON GENERAL OF THE ARMY AND COMMANDER, U.S. ARMY MEDICAL COMMAND

General SCHOOMAKER. Chairman Levin, distinguished members of the committee: Thank you for the opportunity to discuss the total transformation that the Army is undergoing in the way we care for soldiers and their families. We are committed to getting this right and providing a level of care and support to our warriors and their families that is equal to the quality of their service.

Secretary Geren has eloquently expressed this transformation in his testimony. The Secretary, the Chief of Staff of the Army, and the rest of the Army leadership are all actively involved with every stage of the AMAP, which you, sir, alluded to in your opening comments, and to the transformation it embodies. In less than 1 year, the Army has funded, staffed, and written doctrine for a fundamental change in warrior care, a truly remarkable achievement.

For example, as Secretary Geren mentioned, we now have more than 2,500 soldier leaders assigned as cadre to 35 WTUs that did not exist this time last February. This contrasts with fewer than 400 cadre for the same group of patients last February.

The most significant feature of these WTUs is this triad of care that has been alluded to, consisting of a primary care physician, a nurse case manager, and a squad leader working together to care for the needs of each individual. The regular meetings and the coordination between each leg of the triad serves to create a web of overlapping responsibility and accountability which embraces each warrior for the duration of the treatment and recovery.

Our squad leaders, many of them combat arms soldiers and former patients—two of the officers that you were introduced to earlier have been patients at Walter Reed and have been combat injured—are trained and responsible for the well-being of a small group of warriors in transition, just as any Army unit. These soldiers that you met just a minute ago are four combat-tested leaders and they spend their days at Walter Reed looking out for the best interests of the wounded, ill, and injured soldiers. They really are the backbone of the AMAP.

Sir, with your permission I'd like to introduce two of my battle buddies in putting together this plan. I'd ask Brigadier General Mike Tucker and Colonel Jimmie Keenan just to stand up. These are two of the principal architects of the AMAP. Mike is a career armor officer. We took him out of the armor school at Fort Knox. Jimmie Keenan is a career Nurse Corps officer, and they truly are the architects and executors of the AMAP. We couldn't have done it without them. [Applause.]

Chairman LEVIN. Thank you for introducing them. Thank you for your service.

General SCHOOMAKER. Another example of the difference between today and last year: One year ago, our wounded, ill, and injured soldiers believed that their complaints were falling on deaf ears within the Army. Now we've established a MEDCOM-wide ombudsman program with ombudsmen at 26 of our installations and we're hiring more each week. Everyone at our medical treatment facilities knows who the ombudsman is and how to find him or her. Many are retired NCOs and officers with experience in medical care. They work outside of the local chain of command, but they have direct lines to the hospital commander, the installation commander, and the garrison commander to get problems fixed.

We've also established a 1–800 wounded soldier and family hotline that's outlined on this card that every soldier and family carries, in order to offer wounded, ill, and injured soldiers and their family members a way to share concerns on any aspect of their care or administrative support. We respond to these inquiries within 24 hours of the call. So far we've received in excess of 7,000 calls.

Another improvement in the care of soldiers over the last year is the development of multiple feedback mechanisms so that we can see ourselves from a variety of perspectives. I think this is a lesson that we learned last year. We monitor and evaluate our performance through 18 internal and external means, including the ombudsman and the hotline that I addressed earlier. But we also have a contracted industry leader in patient surveys that we look at very carefully.

In addition, we host numerous visits from Members of Congress and your staffs. In January alone we opened our WTU doors to more than a dozen congressional visits. These visits give us a valued external perspective and allow us the opportunity to be as open and transparent in our operations as possible. Your feedback and the feedback of your staffs on these visits has been instrumental in our success.

As you well know, despite these successes, there's much progress still to be made. We still need more research on psychological health and TBI. Congress jumpstarted us last year with supplemental funding, for which we are very grateful, but research must be a continuing priority effort.

We need to continue to look at the disability, the physical disability evaluation system (PDES) and ways to make it less antagonistic, more user-friendly, and more understandable to the soldiers and their families. I believe the pilot program that started in the National Capital Region is a good start, but, as each one of the

members of the panel have mentioned, we'd like to see changes made in the PDES made legislatively as aggressively as possible.

We need your continued support so that we can move forward together in 2008 much as we did in 2007. This year's National Defense Authorization Act was very consistent with how the Army is approaching wounded warrior matters. I truly appreciate the flexibility you have provided us to develop policies and achieve solutions. Your bill not only helps warriors, it helps families, it helps the health care providers caring for them. Thank you for taking the time to listen to us and to work with us.

The Army's unwavering commitment—a key element of the warrior ethos is that we never leave a soldier behind on a battlefield or lost in a bureaucracy here at home. We are doing a better job of honoring that commitment today than we were on this day last year. In February 2009 I want to report back to you that we've achieved a similar level of progress as we did over the last year. I'm proud of Army medicine's efforts over the past 232 years and especially over the last 12 months. I'm convinced that, in coordination with the DOD, VA, and Congress, we have turned the corner.

Thank you for holding this hearing and thank you for your continued support of the warriors that we are so honored to serve. I truly look forward to your questions.

[The prepared statement of General Schoomaker follows:]

PREPARED STATEMENT BY LTG ERIC B. SCHOOMAKER, USA

Chairman Levin, Senator McCain, and distinguished members of the committee, thank you for the opportunity to discuss the total transformation the Army is undergoing in the way we care for soldiers and families. We are committed to getting this right and providing a level of care and support to our warriors and families that is equal to the quality of their service.

Secretary Geren eloquently expresses this transformation in his testimony. The Secretary, the Chief of Staff of the Army, and the rest of the Army leadership are all actively involved with every stage of the Army Medical Action Plan (AMAP) and the transformation it embodies. Senior Army leadership has made it very clear that they are in lock step with the following statement by Secretary of Defense Gates, "Apart from the war itself, this department and I have no higher priority."

What I would like to highlight for you today are some of the tangible impacts of the transformed system explained by Secretary Geren. In doing this, I would first point out that, in some aspects, the concerns reported at Walter Reed Army Medical Center (WRAMC) were an unintended consequence of the extraordinary success of modern battlefield medicine. Thanks to improvements such as the Joint Theater Trauma System, state-of-the-art evacuation system and improved body armor, over 90 percent of those wounded in Iraq and Afghanistan survive, making this the highest survival rate in the history of warfare. As a result, there are many more wounded soldiers with complex injuries struggling to recover than in any previous war. In today's highly motivated All-Volunteer Army, this translates to an unprecedented number of soldiers determined to rejoin their units or to transition back to their communities as proud and productive veterans.

At WRAMC, where soldiers are able to participate in the center's state-of-the-art rehabilitation programs, the result has been a population of outpatients six times greater than this premier medical center was designed to handle. To tap this extraordinary determination, the framers of the AMAP realized the need to provide injured soldiers a mission of their own: to heal fully enough to transition back to duty or become a productive, responsible citizen in society. As a result, WRAMC and Army medicine have been reorganized to better enable soldiers and their families to accomplish this goal.

The changes have made a lasting imprint on wounded soldiers and their families throughout this Nation. According to Major Steven Gventer, a soldier wounded in Iraq by a rocket propelled grenade round who is currently commanding one of the companies that make up the Warrior Transition Brigade at Walter Reed, the changes brought about as part of the AMAP ". . . did a great service to soldiers.

We have done everything possible for these soldiers and are continuing to get better every day."

There are now more than 2,400 individuals assigned as cadre to the 35 Warrior Transition Units compared to less than 400 as previously organized. These cadres are trained specifically for this mission and they truly know the wounded, ill, and injured soldiers and families for whom they provide care and support. They escort troops to meetings, act as their advocates, field their calls, and even pick up relatives at the airport. As Major Gventer puts it, "It's a job that entails just about anything and everything that allows the Warrior in Transition to focus on his or her mission, which is to heal."

Most telling as to the progress we have made are observations like those of Army Captain Elvind Forseth, who suffered hand, arm, and eye damage when a roadside bomb hit his HMMWV in Mosul on January 4, 2005 and has been recovering since at Walter Reed. Captain Forseth states he has seen great changes, "It's fantastic. This is the first time in a long time that I didn't absolutely hate being in here." Captain Forseth, 34, has submitted his paperwork for medical retirement and says the process is running smoothly.

Staff Sergeant Michael Thornton is assigned to the Warrior Transition Battalion at Fort Sam Houston, TX. While serving with the 4th Infantry Division near Baghdad in September 2006, he sustained burns over 33 percent of his body when the vehicle he was traveling in hit a roadside bomb. He was transferred to what was then the Medical Hold Company to convalesce. In June 2007, the company to which he was assigned became a Warrior Transition Unit as the AMAP was implemented. Staff Sergeant Thornton states that, since then "Things flow more efficiently. It seems more organized. It's good to have dedicated leadership who handle just our issues. In the past, some wounded soldiers were also serving as squad leaders at the Medical Hold Company. They had appointments too, so it's better to have dedicated leadership. This is the best place I've seen in the Army. We have great docs and so many people who care about us. I've seen issues like a pay problem I had that was resolved with their help the same day. They go out of their way to take care of you and they're good at it."

It has also been meaningful to see how the civilian health care community views the changes that we have made. One expert assessment was recently made by William H. Craig, a civilian health care executive with 17 years experience who currently serves as Vice-President of Clinical Support for Cook Children's Medical Center in Fort Worth, TX. Mr. Craig spent a week with the Warrior Transition Brigade at WRAMC, viewing firsthand how the Army has improved the transition process for outpatient soldiers and to see if the Army's way might have application in the civilian health care world. Mr. Craig's observations include:

> "From a professional standpoint, I was most impressed with the Army's organizational and leadership efforts through the Warrior Transition Brigade. The Army has taken a process-based approach to managing soldiers from the time they arrive at Walter Reed until they leave to return to duty or to civilian life. The Army developed a system through the Warrior Transition Brigade that incorporates both daily people-management needs and medical care needs of the soldier into an organizational structure that brings significant improvement to the transition process. It is impressive to see an organization like the Army, which I have always perceived to be very command and control oriented in leadership style, actually be adaptive in its leadership style and incorporate a flexible approach based on the needs of this wounded soldier population."

Mr. Craig continues that, "While my experience in the health care industry has shown we do a good job of case managing on the inpatient side, it seems to me our systems for outpatient case management are not as well developed as the Army's. When assessing the needs of their wounded soldier population, the Army developed a concept I believe complements the medical resources of an organization like Walter Reed and effectively meets the soldier's outpatient case management needs. This is referred to as the Triad of Care and incorporates three disciplines critical to managing the outpatient process once the soldier is discharged from inpatient status."

Mr. Craig concludes with, "My week at Walter Reed with the Warrior Transition Brigade proved a point I have experienced many times in my career: if you give an organization the right level of resources combined with the right people to lead and execute, it can accomplish many great things."

I can think of no more fitting way to conclude my remarks than with this endorsement from such a respected member of the civilian health care community. The AMAP is the right response at the right time and in the right place for Army medicine and the United States Army. We see the positive impact of these changes every

day as we encounter soldiers and families on the wards and in our clinics. It can be very rewarding to see the progress and growth.

It can also be very frustrating when, despite all of our efforts, we have bad outcomes. We continue to face challenges that require blunt honesty, continuous self-assessment, humility, and the ability to listen to those in need. It is the Army's unwavering commitment to never leave a soldier behind on a battlefield nor lost in a bureaucracy. The changes initiated by the AMAP are transformational because they address the new requirements and costs of sustaining an All-Volunteer Force in an era of persistent conflict.

I want to ensure Congress knows that the Army Medical Department's (AMEDD) highest priority is caring for our wounded, ill, and injured warriors and their families. I am proud of the AMEDD's efforts over the last 12 months and I am convinced that in coordination with the Department of Defense, the Department of Veterans Affairs, and Congress, we have "turned the corner" toward establishing an integrated, overlapping system of treatment, support, and leadership that is significantly enhancing the care of our warriors and families. Thank you for holding this hearing and thank you for your continued support of the AMEDD and the warriors that we are honored to serve. I look forward to your questions.

Chairman LEVIN. Thank you, General. Thank you and all the witnesses for your testimony this morning.

Let's try an 8-minute first round. We will try to work through that roll call vote that's coming up in 10 or 15 minutes, which some of us can just go and vote and come back, so we can try to keep it seamless. As you folks are working on seamlessness, we'll try to do the same thing here this morning.

Studies conducted by the Veterans Disability Benefits Commission concluded that the VA standard for assigning disability ratings for PTSD is inadequate. These studies showed a significant discrepancy between the disability ratings assigned by the DOD and the VA for servicemembers with PTSD. The commission found that of 1,400 servicemembers who were rated by both the DOD and the VA for PTSD, the DOD assigned disability ratings of 30 percent or higher to only 18 percent of that group of 1,400 servicemembers, while the VA assigned ratings of 30 percent or higher to 90 percent of that same group of individuals.

Now, that is a stunning difference. That's not a few percentage points. The same people, the same 1,400, not 1,400 people over here and 1,400 people over there. It's 1,400 people who were the same. The DOD gave disability ratings of 30 percent or higher to 18 percent of that group and the VA gave ratings of 30 percent or higher to 90 percent of those same individuals.

Now, even before we passed the Wounded Warrior Act the law required the DOD to use VA standards for rating disabilities, but in practice the Services deviated from those standards, in many cases resulting in lower disability ratings than assigned by the VA for the same disability for the same person.

The Wounded Warrior Act specifically requires the DOD to use the VA standard. It authorizes deviation only when the deviation will result in a higher disability rating for the servicemember. Now, you've described this pilot project where we're going to have a single exam followed by hopefully a single rating, and we very much welcome that. I think you said there's 120 people in that pilot project.

But in the mean time, while that project is going to take a year, we have a legal requirement now for the DOD to implement the requirement in law that restricts deviation from the VA standard to those circumstances where it benefits the servicemember. I

think, let me ask you, Secretary Chu, how are you going to implement this requirement?

Dr. CHU. Of course, Mr. Chairman, as you have pointed out, it has been longstanding policy of the Department that we're supposed to use the VA rating schedule. There are differences in outcomes. We're aware of that. That's why we are so excited about this pilot program, which the Secretary has asked that we proliferate across the Department as soon as it's practical to absorb its lessons about the administrative issues that need to be addressed.

The ultimate safeguard—these are basically clinical judgments reaching different conclusions. The ultimate safeguard is just to have one agency come to the conclusion, and that is the central feature of the pilot program, which is we'll use VA's disability ratings.

Now, there will still be an issue here, and this is where the Dole-Shalala proposal I think is important, because our fitness decision will be on those conditions that speak to that issue. It will not necessarily be all the conditions the individual has.

Chairman LEVIN. My question is, you have a pilot program over there. You say the ultimate answer is to have one rating and you're right and that's why we put it into law. But in the mean time, we can't accept that kind of a deviation.

Dr. CHU. I agree, sir.

Chairman LEVIN. For the same people.

Dr. CHU. I agree, sir, and we are trying to reinforce that it is one schedule. I do think that the solution, as we all agree, is a single examination system, and we are moving that way.

Chairman LEVIN. We're going to need to know what are you doing in the mean time until that system is put in place to reduce that deviation. If this were a difference between 5 percent deviation or 10 percent deviation, that would be one thing. But this is 90 percent versus 18 percent. That is totally unacceptable even as an interim differential.

Dr. CHU. I would agree, sir. I do think I should emphasize for the record that an earlier study looked at a wider range of conditions; the average difference between the two agencies was 8 percentage points.

Chairman LEVIN. All right. On PTSD.

Dr. CHU. PTSD is a particular issue, although it's also true that VA has recently revised PTSD ratings for many of the veterans involved in older conflicts, and that may be partly explaining the large differences that are reported. DOD does the rating at the time of discharge. VA may adjust that rating across the veteran's longer life history.

Chairman LEVIN. Secretary, these are the same 1,400 people.

It doesn't cover veterans from older conflicts. These are the same 1,400 people.

We're going to give you 30 days on this one, to tell us what action's going to be taken to reduce that differential, for the reasons I gave.

Now, there's another provision in the law that requires the establishment of a board to review the DOD disability ratings of 20 percent or less. I'm wondering, is that board—do you have plans now to appoint that?

Dr. CHU. We intend to appoint that board, sir. It is not yet appointed. But we fully understand the requirement of the statute, which is to review all the older cases since the beginning of this conflict.

Chairman LEVIN. Where there's 20 percent or less.

Dr. CHU. Where there's 20 percent or less.

Chairman LEVIN. That's a critical issue in terms of benefits and family coverage for medical care.

Please give us an estimate: 30 days, you think?

Dr. CHU. I think 1 to 2 months to get it established, yes, sir; I think that's fair.

Chairman LEVIN. All right.

[The information referred to follows:]

UNDER SECRETARY OF DEFENSE
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WASHINGTON, D.C. 20301-4000

PERSONNEL AND
READINESS

MAR 11 2008

The Honorable Carl Levin
Chairman
Committee on Armed Services
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

You asked at the hearing on Wounded Warriors, February 13, 2008, that we clarify what actions we are taking to reduce the disparities between the Department of Defense (DoD) and the Veterans Affairs (VA) ratings for specific conditions in the existing system, pending proliferation of the single exam model now being tested in our pilot. This letter responds to your question.

To the extent feasible, the Department is now required by section 1642, National Defense Authorization Act 2008 (NDAA), to follow the VA Schedule for Rating Disabilities (VASRD) and decisions of the Court of Appeals for Veterans Claims. Any deviations from the VASRD would be based on jointly prescribed criteria established by the DoD and VA and would result in a greater percentage rating than would otherwise be provided under the VASRD. To ensure compliance with section 1642, DoD requested and the VA is providing the Decision Assessment Documents (the interpretation of the Court decisions) to DoD. These documents will contribute greatly in clarifying any changes in the application of provisions in the VASRD and will help ensure that both Departments are fully aware of relevant court decisions.

For specific problematic Global War on Terrorism injuries highlighted by the Scott Commission as priorities for VASRD revision--such as Post Traumatic Stress Disorder (PTSD) syndrome, Traumatic Brain Injury (TBI), and burns--both Departments are working to update diagnoses and the respective rating schedules. The VA continues to develop a separate PTSD rating schedule. The proposed draft schedules addressing ratings for residuals of TBI and burns were published in the Federal Register on January 3, 2008. A summary of the two draft schedules are below:

- The revised burn schedule will clearly define VA's policies concerning the evaluation of scars, including multiple scars. VA proposes to incorporate "burn scars" into the title of the diagnostic codes most appropriate for evaluating scars. Previously burn scars were generally rated by DoD only if they impacted motion and mobility.

- The revised VA schedule for TBI proposes to provide detailed and updated medical criteria for evaluating residuals of TBI. VA has proposed to change

the title, provide guidance for the evaluation of the cognitive, emotional/behavioral, and physical residuals of TBI, direct raters to consider VA special monthly compensation for problems associated with TBI, and revise the guidance concerning the evaluation of subjective complaints.

VA received a number of comments on the proposed rule and is currently assessing them.

In the specific case of mental health ratings, especially as they relate to PTSD, there were some differences in how the two Departments utilized the schedule. The Code of Federal Regulations (CFR), Section 4.129, Mental disorders due to Traumatic Stress, mandates VA to rate in accordance with the following: "*When a mental disorder that develops in service as a result of a highly stressful event is severe enough to bring about the veteran's release from active military service, the rating agency shall assign an evaluation of not less than* ***50 percent and schedule an examination within the six month period*** *following the veteran's discharge to determine whether a change in evaluation is warranted.*" Prior to the passage of section 1642 of the NDAA, DoD was not bound by this portion of the CFR and rated according to the §4.130, Schedule of ratings-mental disorders.

DoD application of the mental health ratings in light of section 1642 is under review. The more enduring fix to this problem is the creation of a rating schedule for PTSD. VA is working hard to develop a separate schedule specific to PTSD based upon the evaluation criteria in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, published by the American Psychiatric Association.

Additionally, to provide oversight of consistency of ratings between the Military Departments, DoD in May 2007 instituted quarterly data reports and an annual data report that enable the Department to analyze disposition data and problematic conditions. I have charged the Disability Advisory Council, a consortium of Disability Evaluation System administrators and health officials, to review the data and address the inconsistencies as they arise.

The Department appreciates your interest and looks forward to working with the Congress to address concerns with the evaluation of our disabled Service members.

Sincerely,

David S. C. Chu

cc:
The Honorable John McCain
Ranking Member

Chairman LEVIN. Secretary Mansfield, has the VA updated the VA schedule for rating disabilities for PTSD?

Secretary MANSFIELD. It's currently under way, sir. It has to go through the Federal review process.

Chairman LEVIN. What's the timetable on that?

Secretary MANSFIELD. The process itself requires 30 days for public comments and then a follow-up of 30 to 60 days to review the comments, prepare a final rule, and get Office of Management

and Budget clearance to publish. Then we would act after that. So I would imagine 90 to 120 days. It has been a highlighted issue within the Department and within VBA, our benefits administration.

Chairman LEVIN. There was a recent series of Denver Post articles that report that 79 soldiers who were determined to be medical no-gos have been knowingly deployed to Iraq. General Schoomaker, this question is for you. The most recent article describes a soldier being taken from a hospital where he was being treated for bipolar disorder and alcohol abuse so he could be deployed to Kuwait. 31 days later he was returned to Fort Carson because health care professionals in Kuwait determined that he should not have been sent there in the first place because of his medical condition.

These articles quoted email from Fort Carson's Third Brigade Combat Team that says: "We have been having issues reaching deployable strength and thus have been taking along some borderline soldiers who would otherwise have been left behind for continued treatment."

Are these reports accurate? What's the Army doing to address them? Maybe Secretary Geren and General Schoomaker. Let me start with you, Secretary, and then I'll go to the General.

Secretary GEREN. We are looking into those issues. Sir, before a soldier deploys they are evaluated and it's a subjective process to determine whether or not they are fit for deployment, and judgment is exercised. We've had this issue come up in a number of deployment platforms around the country, in fact one this time last year that was raised down at Fort Stewart.

I guess the essential point is that the judgment is exercised at the point of deployment, and sometimes that judgment turns out to be wrong.

Chairman LEVIN. Is there a shortage of deployable strength that is now causing some of these decisions to be made that otherwise would not be made?

Secretary GEREN. That should not be happening. I can't tell you that it's not, but it certainly should not be happening. But every soldier must be considered, whether or not he or she is fit for duty, and if not they should not be sent, and everyone understands that. I don't believe we found any evidence that the pressure has caused people to be sent that shouldn't have. Maybe cases where something was overlooked or where a mistake was made, but the commanders who evaluate these soldiers understand what the requirements are and should never send anybody that's unfit. But we look into every one of these cases.

Chairman LEVIN. Are you familiar with that email, that article?

Secretary GEREN. Yes, sir, I am familiar with the article.

Chairman LEVIN. Have you checked the person who wrote that email to say that that is not an acceptable reason for deploying somebody? Could you do that?

Secretary GEREN. Yes, sir, I certainly could.

[Additional information supplied for the record.]

SECRETARY OF THE ARMY
WASHINGTON

OCT 10 2008

The Honorable Carl Levin
Chairman, Senate Armed Services Committee
Washington, DC 20510

Dear Mr. Chairman:

Thank you for bringing to my attention during the February 13, 2008 Senate Armed Services Committee hearing the allegations that Soldiers assigned to Fort Carson's 3rd Heavy Brigade Combat Team (HBCT), 4th Infantry Division were deployed despite their "no go" medical status. I appreciate the opportunity to provide you the results of the Army's investigation of these allegations.

The Department of the Army Inspector General (DAIG) has conducted a thorough inquiry into this matter. A detailed summary of the results of the inquiry is attached. In short, the DAIG found that:

- Soldiers at Fort Carson were processed properly by the Soldier Readiness Center medical providers,
- Commanders properly exercised their authority when determining whether to deploy their Soldiers, taking into account advice and recommendations from unit and installation medical providers,
- Commanders and medical providers were either unaware of the requirement to request a medical waiver or didn't understand the process for requesting a medical waiver, and
- The waiver request process itself requires further development, as no procedural guidelines have been published to date.

In other matters, the Special Inspection of Army Mental Health Care and the Army-wide Inspection of the Pre-deployment Medical Screening and Decision Making Process are still ongoing. I will provide the results of these inspections to you upon their completion.

Thank you for your inquiry into this matter and for your continued support of our Soldiers, their Families, and the Army.

Sincerely,

Pete Geren

Enclosure

Copy Furnished:
Senator Mitch McConnell

Summary of Department of the Army Inspector General Investigation

Issue One: That Soldiers assigned to 3rd HBCT, 4th Infantry Division were not properly screened for medical issues before deployment under Army Regulation 600-8-101, Department of the Army Pamphlet (DA Pam) 600-8-101, Personnel Processing (In-, Out-, Soldier Readiness, Mobilization and Deployment Processing), and Department of Defense Instructions (DoDI) 6490.03, Deployment Health:

A review of the deployment processing and medical files of Soldiers found non-deployable by the Fort Carson Soldier Readiness Center (SRC) indicated that all Soldiers were processed properly by SRC medical providers and staff. Initially, 90 Soldiers were identified as non-deployable – 54 Soldiers were eventually cleared for deployment by the SRC and/or medical providers, while 36 were not cleared by the SRC before deployment. These 36 Soldiers were cleared for deployment by their commanders who used a commander deployment authorization memorandum to document their consideration of the Soldiers' medical conditions and functional limitations.

Issue Two: That 3rd HBCT, 4th Infantry Division deployed Soldiers with medical and behavioral health issues in contravention of the Department of the Army Personnel Planning Guidance (PPG), Chapter 7; United States Central Command Modification 8, Tab A to the Operation IRAQI FREEDOM Operations Order (USCENTCOM Mod 8, Tab A to the Operation Iraqi Freedom Operations Order); AR 40-501, Standards of Medical Fitness; or Office of the Surgeon General (OTSG)/Medical Command (MEDCOM) Policy Memorandum 06-036:

The preponderance of the evidence indicates that commanders properly exercised their authority when determining whether to deploy their Soldiers, taking into account advice and recommendations from unit and installation medical providers. Before the deployment, commanders met with medical providers weekly, and in some instances daily, to discuss individual Soldier medical conditions and limitations. Commanders made deployment decisions concerning Soldiers with medical conditions on a case-by-case basis and assigned duties to such Soldiers based on their functional capabilities and limitations.

US Army MEDCOM policy provides that the commander decides whether an individual Soldier deploys (unless that Soldier is pregnant, HIV positive, or has Hepatitis B or C). Although *USCENTCOM Mod 8, Tab A* to the Operation Iraqi Freedom Operations Order imposed a medical waiver requirement in all other instances, this modification was relatively unknown and did not contain procedural guidance for processing waiver requests.

Historically, it is the commander's decision whether to deploy a Soldier. Once competent healthcare professionals have assessed a Soldier's medical condition and prescribed the Soldier's limitations, the commander is in the best position to determine whether that Soldier, operating within prescribed limitations, can make positive contributions to mission accomplishment.

Issue Three: That 3rd HBCT, 4th Infantry Division did not request medical waivers for Soldiers in accordance with the Under Secretary of Defense Policy Guidance for Medical Deferral Pending Deployment to Theater of Operation; MEDCOM Memorandum, dated April 24, 2007, Subject: Deployment Limiting Psychiatric Conditions and Medications; or United States Central Command Modification 8, Tab A to the Operation Iraqi Freedom Operations Order:

> Testimonial and documentary evidence indicates that commanders and medical providers were either unaware of the requirement to request a medical waiver or didn't understand the process for requesting a medical waiver. Moreover, the waiver request process itself requires further development; to date no procedural guidelines have been published. This concern has been brought to the attention of the CENTCOM Surgeon.

Chairman LEVIN. Do you want to add anything to that, General?

General SCHOOMAKER. Sir, I have not seen the case myself. I am familiar with the story. My understanding at this point, because the soldiers who possess those profiles who were deployed, to include the soldier who is the centerpiece of the article, their profiles and the decision to deploy have been looked at carefully. In all the cases in which soldiers were deployed with profiles, they were placed in positions and in conditions which would be supported by their profile. The profile itself does not limit deployment. My understanding of the index soldier was that he was not hospitalized and that the opinion of outside consultants was that his condition should not limit his ability to be deployed. But I think it's still being looked at.

Chairman LEVIN. The email itself, however, says that "We have been having issues reaching deployable strength." I mean, that's a contemporaneous email and that should not be a factor. Would you both agree with that?

General SCHOOMAKER. Yes, sir.

Secretary GEREN. Yes.

Chairman LEVIN. So whoever thought that was a factor has to be corrected, and that message has to be made clear across the board. Would you agree with that?

General SCHOOMAKER. I agree with that.

Chairman LEVIN. Thank you.

Senator Warner.

Senator WARNER. Thank you, Mr. Chairman.

Gentlemen, those of us in the Senate who have had the opportunity to work on these issues have received a great deal of information, indeed support and learning, from the families of these various soldiers, sailors, airmen, and marines that have suffered these injuries. I've been particularly fortunate to have had access and brought to my attention the wives of a number of these individuals who have on their own initiative fought a very courageous battle. I'm pleased to say that in our audience this morning is Sarah Wade, whose husband in 2004, Sergeant Ted Wade, was severely injured. He's still in the process of rehabilitation, and she's accompanied by Meredith Beck, who is a very active member of an

organization called Wounded Warrior Project, a nonprofit organization.

I wonder, Mr. Chairman, if we'd invite those two to stand and be recognized here. They are examples of the families that stand by their man. [Applause.]

Secretary Geren, you visited with me the other day. It's interesting how forthright you are with sharing the information, good news and not so good news, with our colleagues. I feel that in discharging your responsibilities, certainly with this Member of Congress, you've been absolutely forthcoming and factual.

You showed me a series of charts about the things that were concerning you. Among them was the very alarming rate of suicide. It's particularly high in the Reserve and Guard components. I'd like to ask you to lead off what steps under your leadership the Department of the Army is taking, and then maybe we'll go to the other witnesses, who have a broader responsibility for the other departments, to the extent that the Navy, the Air Force, and the Marine Corps are suffering some from this problem.

Secretary GEREN. I'd be glad to lead off, but I'd also like to ask General Schoomaker to add as well because this is an area where the leadership of the Army has focused a great deal of attention, and not just over the last few months. We've recognized over the last few years an alarming growth in the rate of suicides. We last year experienced the highest level of suicides we've had since we started tracking suicides in 1980.

Senator WARNER. So that's a period of 28 years.

Secretary GEREN. Yes, sir. That's when we began tracking it. We can't tell how it compares to prior years. But we've seen a steady increase over the last 5 years, and it's something that everybody in Army leadership understands they're part of the solution to that effort.

Every week we have a balcony briefing. We bring all the senior leadership in the Army together in the Pentagon Wednesday morning. One of the slides we look at is the suicide incidents over the preceding week. We want to make sure every leader in the Army recognizes that it's a part of his or her responsibility to help address this.

We have a very comprehensive effort under way right now—and General Schoomaker can provide you greater details, but we are looking at innovative ways to approach it through different types of training for soldiers, for leaders, working with the chaplains, working with families.

I think one of the most important things we can do is overcome the stigma over getting help for mental health issues. We have soldiers that don't come forward and ask to be helped. Until we break down that stigma, until we break down that barrier, we're going to have soldiers that are in desperate need that don't get the help they need.

This PTSD training that we're doing, it's not just PTSD and TBI, but I think it's going to break down the stigma across the whole range of mental health issues and help soldiers and family members to recognize, this soldier has a problem, come forward and do something with it.

But we are looking at trying to understand the trends. We have seen some of these deaths associated with misuse of narcotics and other drugs that were lawfully prescribed and perhaps misused, a mix of alcohol and drugs. Most of them result from a failed relationship or some other type of traumatic event in their life, exacerbated by the stress that they're under and the pressures that they're under. Also, leaders in the Army, because the system is stressed, aren't able to put their arm around the soldier and understand what's going on with his life.

But from the lowest ranks to the most senior ranks, this is a problem that we are working to address. I would like to ask Dr. Schoomaker—he's done a great deal of work in this area and I think that he has much to share with the committee.

General SCHOOMAKER. Thank you, sir.

Thanks for the question. You're right, there are two trends right now that we are watching very carefully that the Secretary has alluded to. The first is suicides within the Army at large. I think Secretary Geren has really outlined the multidisciplinary approach that we have. It starts with small unit leaders and fellow soldiers and their ability to recognize a soldier who may be in trouble, that may have problems with coping with a lost relationship, which includes in some cases a loss of a relationship with the Army itself because of misconduct and the like.

It's compounded by drug or alcohol use, and certainly the families play a very critical role. We are looking at this in a multidisciplinary way. We have looked carefully across the principle staff who are responsible, from the chaplains through the personnel community, through those that represent leadership at large, and then the medical community. We're prepared to come in front of the Secretary with some recommendations about how we will be approaching suicide prevention in the near future.

The other trend that we're looking at very carefully is a trend in accidental deaths, especially within our WTUs. Now that we have concentrated approximately 9,500, almost two brigades worth, of soldiers who have illnesses or injuries, some combat-related, some other, within these WTUs under the care of cadre with a primary care provider and nurse case managers, we recognize now that a number of them have a constellation of drugs—drugs for anxiety, drugs for sleep, drugs for pain, which in combination, especially if used with alcohol, can be a lethal cocktail.

We have, unfortunately, lost over the last few months several soldiers. We've brought together a team. The Secretary and the Chief of Staff of the Army charged me about 10 days ago with expeditiously bringing together a team of experts to look at the factors that lead to these accidental deaths. I contrast these with suicide. I don't believe these are suicides. We've looked very carefully to separate those that are suicides from those that are truly accidental, and those that we are seeing are accidental deaths. We've looked at the major factors and are trying to eliminate those factors.

Senator WARNER. Secretary Chu, to the broader aspects of it.

Dr. CHU. Yes, sir. The Marine Corps is already beginning to emulate the Army's practice of the chain teaching of mental health indicators, responsibilities at every level of command. The Sec-

retary of Defense, to deal with the stigma issue—a small but important step—has advocated and the administration, I believe, will soon decide to revise the instructions on security questionnaires so that we set aside a positive answer on have you sought mental health assistance if it has to do with PTSD or the various issues that relate to combat service.

I do think there are two issues here. One is the trend, where we are all concerned with the Army's increase. Also the level, the Department, even with this adverse trend, is approximately where civilian rates are. That doesn't mean that's where we want to be. Within the Department we do have a Service that's at much lower level, absolute level of suicide, the Air Force. So one of the things we're doing is asking all the departments to look at what's successful about these Air Force programs that might be translatable to their circumstances.

We are very excited with this Center for Psychological Health and Traumatic Brain Injury Congress has so generously funded. It's stood up in a provisional way, being led by an Army psychiatrist, Colonel—soon General, I guess—Dr. Loree Sutton. I've asked her to focus not just on prevention after the fact, but what can we do before the fact; and how can we help the resiliency of our people to deal with the stresses that military life does bring to them. Should we, for example, be asking questions all the way back at the enlistment point that we don't ask today or having screens that we don't use today?

We do, of course, use one broad screen already that is a predictor of can you stick with a military career. That's the high school diploma. That's why they're so important in our recruiting standards.

So we are trying to take a broad-based approach, ranging from the specific questions and examples to the strategic, how should we be recruiting people from American society so they can successfully serve in a very difficult environment?

Senator WARNER. I actually say to this distinguished panel, we have to have the infrastructure to carry forward all of these various initiatives, literally the bricks and the mortar and the roofs and the ceilings and so forth. Where are we with regard to, first, maintaining Walter Reed's physical plant such that it can continue to deliver that level of health care that these honorable, wonderful people are entitled? Second, the projections of a new facility at Fort Belvoir and the modifications to the infrastructure at the Bethesda center to take on the additional; are we on schedule? Is the budget adequate for these two construction projects?

Dr. CHU. Yes, sir.

Senator WARNER. Is there anything that Congress needs to do to facilitate?

Dr. CHU. Our most important request will, of course, be to support the fiscal year 2009 request in this regard, which does ask for a substantial tranche of money to support a more ambitious plan for the new Walter Reed campus than we had before, and a faster plan. That includes Walter Reed thought about in the large, not just the Bethesda campus, but also, importantly, the DeWitt Army Hospital modernization and the refurbishment at Fort Belvoir.

In terms of the personnel at Walter Reed—that, I think, is always a challenge when you close a base, how you keep everything

up at the top level all the way up to the last day. We have sought and gotten from the Office of Personnel Management additional direct hire authority to make sure we can staff Walter Reed correctly, including the ability to pay special retention bonuses to the personnel there.

But I would defer to Secretary Geren on additional specifics.

Secretary GEREN. General Schoomaker just recently left the post as commander at Walter Reed, so I'd like to ask General Schoomaker to respond.

General SCHOOMAKER. Yes, sir. I think Congress and the leadership of the DOD and the Army sent me and my command when I commanded Walter Reed last year a very clear message that we were to restore Walter Reed to a world-class facility, despite the impending fusion of Walter Reed with the National Naval Medical Center in Bethesda and the formation of the new Walter Reed National Naval Medical Center that the Secretary alluded to.

We've done just exactly that. We have given very clear orders and have had very robust support from the Department to fix all those things that need to be fixed and to maintain both the manpower as well as the clinical practices and the physical plant of the Walter Reed campus.

Senator WARNER. Thank you very much.

Chairman LEVIN. Thank you, Senator Warner.

Senator Ben Nelson.

Senator BEN NELSON. Thank you, Mr. Chairman.

I want to thank our military men and women and those who are on the civilian side who do such an outstanding job to protect our country. Of course, nothing is more important in dealing with their needs than to make sure that the health system we provide for them is the best possible health care system. So we were all chagrined and saddened with the revelations of a year ago.

In terms of what we're working with toward public-private partnering, Secretary Mansfield and Secretary Chu, last year I met with a sergeant in Nebraska from the National Guard who suffered a TBI as a result of his service in Iraq in 2006. When I met with him, he indicated the many challenges he had in getting the care that he required. He was lost in the system on at least two occasions, and he was finally able to get care in Nebraska through a private facility, Madonna Rehabilitation Hospital.

Receiving quality health care in rural States is obviously a challenge in many areas due to resources and geography alone. That's why I believe it's critical that we find partnership opportunities for our public institutions and private institutions to be able to make sure that we get that quality care and we integrate it.

How do you provide for that integrative care for veterans as they transition back into their communities, so that we ensure their long-term care, not simply a short-term situation, but their long-term follow-up care across a wide geographic area? I've been told that local VA hospitals have authority to contract with civilian partners, but in many instances are just very reluctant to do so and we have to continue to press to get them to be able to forge a collaboration.

But is this centralized or decentralized process from the standpoint of the VA? What are your thoughts about how we can make

this system work? We talk about it being seamless. You'll have to pardon me if I find the word "seamless" between the VA and the DOD an oxymoron. Perhaps "nearly seamless" might be something more, that would be more likely achievable. "Seamless" I think is beyond anyone's expectations, given a bureaucracy that is full of what I consider "we-bes": "We be here when you come, we be here when you go." We're going to constantly find that very difficult to purge and converge those systems.

But from the standpoint of the VA first and then the DOD second.

Secretary MANSFIELD. Thank you for that question, Senator. First let me apologize to that individual. The idea that somebody gets lost in the system is something that we do not want, and we're doing everything we can to ensure that we take care of that. So I would apologize to that individual.

Senator BEN NELSON. Sergeant Mac Richards.

Secretary MANSFIELD. I'll get with you and we'll follow up on that.

The idea of TBI care, serious TBI care, started with the fact that the VA since 1992 had four brain injury treatment centers that were doing treatment, care, research, and efforts, and those four centers in Palo Alto, Minneapolis, Richmond, and Tampa became our polytrauma centers. Each one of those brain treatment centers was also co-located with a spinal cord injury clinic, so we had a robust rehabilitation capacity in those hospitals. There's a fifth one on the way hopefully in the next budget.

What we've done since then for the effort to have more geographic representation is had each one of our VSNs, or 17 more VA medical centers, come on line as level two polytrauma treatment centers, so we can attempt to get the treatment more dispersed geographically around the country.

The issue of the private treatment is one that we've dealt with in the past in sharing agreements in various locations to get specialty care that we needed that we didn't have on staff or just couldn't provide.

Senator BEN NELSON. Excuse me. Can that be geography-related as well, not close by, so that they don't have to drive 250 or 500 miles round trip?

Secretary MANSFIELD. Sir, I was going to say, what we are learning and dealing with and attempting to do is deal with the individuals in an effort to bring all the conditions that would apply to bear to make the decision to go forward. I know that Dr. Kussman, the head of our Veterans Health Administration, has made the point that if the people that we're treating don't feel that they're getting the care that they need then we need to work with them in an effort to get it right.

I know that we've done that in many instances where folks are getting treatment that either VA is paying for or in some cases, TRICARE I think is also taking care of the individual. It's an effort that has started, is moving forward, needs the continued emphasis of the leadership, has had continued emphasis, and we will do more.

Senator BEN NELSON. Dr. Chu?

Dr. CHU. Sir, if I could just address the two issues you raise. One is the seamless transition; the other is the question of how we provide quality care to those on a geographically dispersed basis.

On the seamless transition front, we are very excited by the appointment of the first Federal integrated recovery coordinators. Their ultimate responsibility is to make sure there is a plan for that person that is really lifelong in character and that the steps are in place—the mechanisms in place, to be sure that plan is being followed. I think that's a key ingredient in getting us at least to the nearly seamless condition that you set as an immediate goal.

On the question of the geographically dispersed delivery of care, I do think this is where the central proposition of Dole-Shalala is so important. It recommends, and the President's legislative proposal would propose to carry out, that if you're medically retired from the DOD we would end DOD deciding whether you got TRICARE coverage based on the percentage of disability. If you're medically retired you would get TRICARE coverage for you and your family.

Now, I think that's important not only for the families, but also for the issue that you described, because that does give you the right to go to any place you want, essentially, in the United States, and it would end a good deal of this problem, because it's always been a problem for the VA. In many States there may be only two or three VA hospitals and it is going to be a distance for patients to come to that hospital for care, even though the quality reviews across the medical profession in the United States today give VA extraordinary high remarks for the quality of medical care that it delivers. It really is first class.

Senator BEN NELSON. I don't think very often the question is about the quality of care or even recognizing that with the TBI situation, all the research that's going into that, that there's a general perception that we're improving the quality of care. It's availability and the seamless nature of it.

General Schoomaker, this has probably happened to others as well, but I know last week you were interviewed by NPR and you were given the example that somebody allegedly—that Army officials told workers at the VA to stop helping injured soldiers fill out forms and so forth. So much for the idea, as I said, of seamless care and seamless relationships. Probably not the first example of embarrassment and probably not the last.

But it does point to how important it is from the top down and from the bottom up to get it right so that there isn't stovepiping or resistance to this effort to make sure that those who have done it their own way for so long don't frustrate this process by wanting to continue to do it their own way or they know best what way it ought to be done.

I wish you might comment on that. I know you did last week.

General SCHOOMAKER. Yes, sir, and I remain personally chagrined that an effort to really reach out and ensure that the best practices that we were observing, frankly, at Fort Drum were proliferated throughout the system—ironically, we found a system that was working extremely well and yet it was interpreted wrongly.

I will say, first of all, it's very hard for me to say anything ill about the VA. I'm a product. I'm a physician, a product of the VA

system. I was trained in two VA hospitals associated with major universities. This is a great system of care. This is a national treasure. They have set the standard on good, objective outcomes-based care within the country, and I think we're better positioned than we ever have been with leaders like Deputy Secretary Mansfield and the new Secretary of Defense, my former boss General Peake, and General Kussman and others throughout that VA system.

Our response to what we saw at Fort Drum, sir, was that Secretary Peake and Secretary Geren promptly sat down, we hammered out an agreement, a memorandum of understanding with the VA, and we've put that aside. We now have a formal memorandum that empowers VBA counselors at each one of our Army MTFs to fully counsel any soldier or family and make it very clear that they're part of the solution and that we welcome that.

Senator BEN NELSON. But it does point out that it's an ongoing process that you can't measure it simply in terms of time. It's a marathon, not a sprint.

General SCHOOMAKER. Yes, sir. I think your comments earlier about the seamlessness and Secretary Chu's comments—I think the fact is there are seams in the system. I think the earlier comment from the chairman about disability adjudication, which for the military is based upon fitness for duty and within the VA system is based upon the whole person concept, means that you can apply the earlier study to virtually any individual problem and you'll find the same issue there.

We adjudicate disability in the military based upon that one major unfitting condition and we turn to the VA and allow the VA to take all of those conditions that we all jointly recognize are present and adjudicate disability on the basis of the whole person. That's a seam that has to be closed.

Chairman LEVIN. Thank you, Senator.

Senator BEN NELSON. Thank you.

Thank you, Mr. Chairman.

Chairman LEVIN. Thank you, Senator Nelson.

Senator Inhofe.

Senator INHOFE. Thank you, Mr. Chairman.

Chairman LEVIN. Senator Inhofe, I think the vote has either started or is about to start.

Senator INHOFE. How about I go ahead and start and run through my time?

Chairman LEVIN. Would you turn that over to the next person here, and if there's nobody here when you're here just recess until I get back?

Senator INHOFE. Okay, I will do that.

Chairman LEVIN. Thank you.

Senator INHOFE. First of all, General Schoomaker, I appreciate what you said and let me just drive it home, because as long as I can remember, even back when I was in the United States Army, there were complaints about the kind of treatment in the VA centers. Then when I was elected here, oh, about 22 years ago, we had just some real crises. Now, maybe this is unique in our State of Oklahoma, but the treatment was not good.

I can't tell you how that's changed. I had a group in my office yesterday of the veterans and they just rave about it. I have gone

to all the centers, including some of the retirement centers and others. I don't know what's accounted for it, but whatever you're doing, keep doing it that way. It's been great.

Maybe because I'm the only veteran in the Oklahoma delegation, I seem to get more calls and complaints than any of the rest of them do. They're in three areas that have been addressed somewhat in this meeting and by your committee. One is in the disparity between the disability evaluation systems that we've had. Senator Levin talked about that. You've responded to that.

The other two are in transition areas that we've been talking about with Senator Nelson, that is transition into civilian life or into another service of our country. Many of these people who become disabled, they want to continue serving in this transition. Then the transition, of course, that we talked about from DOD to VA.

Now, I understand, from whoever wants to respond to this, that this disparity between the evaluations has been corrected now or is in the process of being corrected in terms of disability evaluations between the various levels.

General SCHOOMAKER. Sir, I think that's a recommendation of the Dole-Shalala Commission that's going to require legislative changes. We can smooth over the bureaucratic steps required between the military system of adjudication and the finding of fitness for duty and the VA system of adjudication of disability, but we currently are not empowered to make this a single system without further legislation.

Senator INHOFE. Are you going to be helping us in drafting the legislation?

General SCHOOMAKER. Oh, absolutely.

Senator INHOFE. Making recommendations?

Dr. CHU. Yes, sir, we'd be delighted to. General Schoomaker is absolutely correct. Until there is a change in the fundamental statute, you will always—even if we each rate each condition with the same percentage, which is the first issue, which we can deal with and we are dealing with, the Department only rules on fitness to serve based on those conditions that affect your military career. You may have other conditions.

Senator INHOFE. In terms of the evaluations, if any of the five of you don't believe it's a problem just call our office and we can provide you with some cases.

Now, in terms of the transition into civilian life or other government services, any further comments any of you want to make about that, because this has been another source of complaints?

Dr. CHU. Sir, one of the things we've done, particularly with this conflict, is organize a series of job fairs, particularly at medical centers, where we especially emphasize the importance of Federal agencies stepping forward, including our own, the DOD.

Senator INHOFE. When did they start? When did you start doing that?

Dr. CHU. About 2 years ago we started these, and we've done about a dozen of these altogether. They are intended to both bring civil employers as well as government agencies together to the military community, not restricted to those who've been recently wounded necessarily, but that's the focus. We have worked very

hard in a proactive way through the Military Severely Injured Center to help the newly injured think about the possibilities for them, what would make sense from their perspective, and how do we link them up with these agencies so they can be successful.

Senator INHOFE. Secretary Mansfield, you touched slightly on this, the transition between the DOD and VA. Could you just address this electronic transfer of data, and are we making progress there?

Secretary MANSFIELD. We're definitely making progress, sir. We've come further than the JEC had. We're in the process now where we can actually exchange information. The issue, though, is that we're working in an effort to make it interoperational. Right now you can read the information, but you can't manipulate it. So we are exchanging information from imaging, from clinics, from pharmacy, and from testing. We're further along the line, but we still have a long way to go.

Of course, part of the issue is that you have an Army record, a Navy record, and an Air Force record that needs to be consolidated, then get access to that through a single data access point. We're working on that.

Senator INHOFE. Secretary Geren, this is more Army sensitive than anything else. The chairman talked about some of them who were deployed who perhaps should not be deployed. But on the other end of that, there are a lot of them who want to be deployed who are not. It seems like there is a greater problem in the Army. Our 45th out of Oklahoma, that's over 2,600, they're over there in Iraq right now. I went down to Camp Gruber when they were preparing for it and while they—the National Guard members—receive TRICARE, they don't have the dental benefits. This seems to be where the problem is. I was surprised to see this, that the DOD has set a Service-wide goal of greater than 75 percent for fully ready to deploy servicemembers and greater than 90 percent for partially ready servicemembers.

Currently, five of the seven Reserve components are below the 75 percent. Now, I have from your report on page 194 those seven and the two that have the great problem are the Army National Guard and the Army Reserves. Everybody else, frankly, is over the 75 percent. But these are not. These are, in the case of the Army National Guard, 45 percent; and the Air Guard, 51 percent.

Now, of those, that's just dental only problems. That seems to be the greatest problem in terms of having these people not ready for a deployment for medical purposes.

It would seem to me that—and I talked to some of them down there at Camp Gruber before they were going—you can't put a bridge in or do the root canal; there's not time during this transition period. Once they get over in the field of combat, they're not going to be able to do those things.

Now, wouldn't one solution that perhaps you might want to consider or you are considering is to somehow have dental benefits? There was a time when the Guard and Reserve really didn't have these overseas deployments and maybe it wasn't necessary then. But it is now, and it seems to be, of the medical—again, I'll repeat that—the 38 percent, is 45 percent is dental only. So that seems to be the biggest problem.

What do you think, Pete?

Secretary GEREN. The experience in Oklahoma is not unique. The dental issue is something that we are looking at very carefully. One of the initiatives that the Chief and I are working on is how to do a better job of fully operationalizing the Guard and Reserve, and medical preparedness for deployment is one of the issues and the dental is always at the top of the list.

So I don't have an answer for you today, but it's something that we are looking at.

Senator INHOFE. If your goal is to reach 75 percent, from the figures I have here pulling the dental problem would put you at 75 percent.

Dr. CHU. Senator, I do know that some units in Oklahoma have adopted a best practice we'd like to see more of them use, which is to use operations and maintenance funds during periods of premobilization drill to bring mobile dental vans to the unit.

Prior to mobilization, and the standard that you've described is what we want all units to be at all the time, so that we don't have to deal with these medical issues post-mobilization.

Senator INHOFE. I appreciate that, because I think—and Mr. Chairman, during your absence I made comments that you talked about how there are some who didn't want to be deployed but were found deployable, but there's probably more who want to be deployed who for some reason or other can't. Or maybe that's unique to Oklahoma, but I sure have heard from a lot of people.

Dr. CHU. Again, I want to praise those units in Oklahoma that use this practice. It is a great solution. It is reasonable in terms of its cost.

Senator INHOFE. Thank you.

Secretary GEREN. Real quickly, Senator, we have a group of guardsmen and reservists that advise the Chief and Army leadership on Guard and Reserve issues. They meet with us regularly, and that has been one of the issues that they've been examining and putting together recommendations in that area. We recognize that challenge. It is expensive, and there's also just some logistical issues associated with it. But we recognize the importance of it and are working through it now.

Senator INHOFE. Thank you.

Chairman LEVIN. Thank you, Senator Inhofe.

Senator Bill Nelson.

Senator BILL NELSON. Gentlemen, thank you for trying to correct this problem and make it right.

Secretary Chu, has Secretary Gates designated a lead agent to implement the TBI–PTSD mental health plan?

Dr. CHU. Yes, we have our Center for Psychological Health and Traumatic Brain Injury. It is the agency that will be executing the generous addition to the budget Congress provided last year.

Senator BILL NELSON. The question was has he designated a person to implement it?

Dr. CHU. The commander is now Colonel, soon General, Dr. Loree Sutton, Army psychiatrist.

Senator BILL NELSON. You all know the problem here and thank you for trying to correct this problem. We have excellent care, for example, for TBI once we can get them into the centers, and one

of those centers is in my State, in Tampa. The problem has been getting them identified and getting them in those centers. As the other Senator Nelson pointed out in a case in his State of Nebraska, I could point out to you many cases in my State of Florida where the military person gets lost between being released from DOD and coming into the VA health care system. So thank you for working on that.

Secretary Geren, I want to go over with you what I had talked to you on the telephone about. I think it needs to come to the attention of the committee: A World War II veteran who was wrongly accused and incarcerated, an African American, during a POW camp revolt in Italy and in the hysteria is swept up and incarcerated for a year. Just this year—so that's some 60 years later—a review of the records, the DOD realizes that it made a mistake. They reversed his dishonorable discharge. They made it an honorable discharge, acknowledged that the U.S. Army was wrong, and 60 years later returns to him the back pay that he would have earned during the 1 year of incarceration, $720.

Now, that's just plain wrong, that someone is denied that and is given 1944 dollars without compensation for at least the cost of living adjustments, which would only be $8,000 in today's dollars.

Chairman LEVIN. Senator Nelson, excuse me for interrupting. I'm going to run and vote and come back. If no one's here when you need to go, just recess.

Senator BILL NELSON. I'll do that, Mr. Chairman.

Chairman LEVIN. Thank you for raising this issue, however.

Senator BILL NELSON. Yes, sir.

Chairman LEVIN. It's of importance to the committee.

Senator BILL NELSON [presiding]. Of course, I appealed to you as Secretary of the Army and then you said you did not have the legal authority. I appealed to the Secretary of Defense and he said he did not have the legal authority. As a result of that, I filed a bill to correct it.

But it seems to me that under equity and fairness an issue that we are addressing here about health care for wounded warriors, that under equity and fairness, a warrior has been wounded by taking away his most prized possession, which is his honor and his liberty, and 60 years later that the U.S. Army and the DOD is saying that they don't have somewhere in the bowels of the Pentagon the ability through equity and fairness to adjust $720 back pay.

Can you share with me, Mr. Secretary, what you think we ought to do to right this wrong?

Secretary GEREN. Yes, sir, I'm glad to. I reacted exactly the same way you did when I learned of this. I'd go so far as to say it's a travesty of justice. $720 today is nothing compared to what that soldier went through and what he suffered, and certainly what $720 would buy you in 1944 and what it would buy you today, it's no comparison at all.

When I learned of this I asked our lawyers to figure out some way to fix this, some way to address this. They kept coming back and saying there's no way to do it. We looked at a couple of different ways and, unfortunately, they kept coming to the same conclusion, and the OSD lawyers agreed with the Army lawyers, that

under the current statutory framework we're prohibited from deviating from that schedule.

So I'm glad that you've introduced a bill and I hope there's speedy consideration of it so that we can right this wrong and try to do what we can to compensate this soldier for what he suffered.

Secretary MANSFIELD. Senator, if I could raise an issue. If he was a dishonorable discharge he would not have been eligible for VA benefits back then. So why don't we check it and see if there's some way that we can look at that situation now that it's been corrected and the VA may be able to assist him.

Senator BILL NELSON. Okay, Secretary Mansfield, we'll do that, and thank you for that suggestion.

Samuel Snow naturally is getting up there in years. He lives in Leesburg, FL. I would pursue this with great vigor because this is somebody who has been wronged. But the reason I'm bringing it up to you is that again it's another indicator of the cold, hard, impersonal rules and regulation on something that is obviously wrong. We've seen this in Samuel Snow's case. We've seen it in how some of these veterans have been handled. We've seen it, for example, in that veteran from Winter Haven, FL, that was lost in the system, the military discharged him, had no indication that he had TBI because they didn't ask, they didn't probe. So he's out there on his own, and he knows something's wrong, and he goes and gets an appointment after waiting, over at one of the VA hospitals at Bay Pines. Then he finally gets there after waiting a couple of months and then they say: Well, we can't handle this; you have to go to the Tampa Haley Hospital, and of course, that's another waiting period.

Somehow, this veteran knew to call me. Of course, the minute we found out what happened he had appointments in the Haley Hospital in the TBI center the next day.

There's something cold and hard and impersonal that we have to break through not only the subject of this hearing, on wounded warriors, but on the treatment of people like Samuel Snow 60 years ago, that his country didn't treat him right and 60 years later is giving him a check and saying, go away. It's wrong. It ought to be corrected.

Secretary MANSFIELD. Sir, I would tell you that we've been working hard to correct that. I would agree with you that it's wrong. We, as I stated in my opening statement, need to ensure that each one of these individuals that steps up, raises their right hand, puts themselves in a position to defend this country and puts themselves at risk, deserves timely access to every benefit that this Nation has promised them. We're working together as hard as we can to make that happen.

I would make the point, in regard to the person you mentioned, with that situation and others, we have changed the rules and regulations to make sure that people with these issues get taken in sooner and quicker and are seen.

I would tell you also that everybody that comes to us is screened for TBI and PTSD, and we're working with DOD on follow-up issues to do that.

But I would agree with you, sir: You have two of the biggest bureaucracies in the world that need a little shaking to make sure that they know that they're dealing with people.

Dr. CHU. Sir, let me also emphasize, as you and Secretary Geren agreed, ultimately the issue with Mr. Snow is statutory. If Congress were willing to give the Secretary of Defense discretion in cases like this, as it has given him discretion in waiving repayments, which we have used extensively, we would be able to avoid the situation.

But it is ultimately not a rule or regulation in the Snow case; it is the law, and we are stuck.

Senator BILL NELSON. If it is the law, we will change it.

Dr. CHU. My plea, sir, is for broad discretion as opposed to the rifle shot, because then you can deal with the unanticipated situation just as you have advocated, and we would like to be in that position.

Senator BILL NELSON. Now, it's hard for me to believe that the DOD in the enormity of its resources and rules and regulations, that there is not discretion somewhere to correct this wrong. As Secretary Mansfield has said already, there's another avenue we might explore with regard to maybe he hasn't been advised of veterans benefits that would be available to him since he had been wrongly, dishonorably discharged, and we will pursue that. I wonder why we had to come to a United States Senate hearing to get to that.

But in the mean time, since I have to recess this hearing so that I can go vote, I wish you in the recess would confer with your assistants and see if there might be any other little angle that we haven't figured out.

Secretary GEREN. Sir, I can assure you we have pushed this within our legal system as hard as we can. I know you get two lawyers together, you get two opinions, but unfortunately we continue to run into the same statutory interpretation. If someone could help us see it differently, we'd be glad. I can assure you we all feel the same about that case and want to help, and appreciate your advocacy and your interest in addressing it statutorily. We believe that's where we are, and we sent it back and sent it back and sent it back and kept getting the same answer. We want to see it fixed as well.

Senator BILL NELSON. The committee will stand in recess subject to the call of the Chair. [Recessed.]

Chairman LEVIN [presiding]. The committee will come back to order. Yes?

Secretary MANSFIELD. Could I have the privilege of speaking, please?

Chairman LEVIN. Sure, Secretary Mansfield.

Secretary MANSFIELD. Sir, in reference to the last discussion about the individual wronged and the ability to deal with that and the need for legislation, I would refer you to Title 38 U.S. Code 503: "Administrative error, equitable relief. If the Secretary determines that benefits administered by the Department have not been provided by reason of administrative error on the part of the Federal Government or any of its employees, the Secretary may provide such relief on account of such error as the Secretary deter-

mines equitable, including the payment of moneys to any person whom the Secretary determines is equitably entitled to such monies."

That's what the DOD needs. That's the VA section and I think that's what DOD needs. It would allow us to go back and look at the situation by virtue of the fact that, with that dishonorable discharge, he was not eligible for a lot of VA benefits and we could not make an adjustment based on that.

Chairman LEVIN. Does the mistake have to have been made under that law by the VA?

Secretary MANSFIELD. No, sir. It says "on the part of the Federal Government or any of its employees." "The Federal Government."

Chairman LEVIN. So if there was a mistake made, which there seems to have been, by the DOD, the VA can act now under existing law?

Secretary MANSFIELD. Yes, sir, for VA benefits.

Chairman LEVIN. For VA benefits. That's part of the deal, as I understand it.

Secretary MANSFIELD. That would be one way to make him whole, to look at what he would have been eligible for: home loan or education or compensation.

Chairman LEVIN. I'm sure Senator Nelson will pursue that. But what you're doing is opening up the avenue that, even though you don't think the DOD has that power—we'll check that in a second—the VA has power if there's a mistake made by any governmental agency that affected the benefits of the VA, that you may not be able to make that soldier whole, but you'll be able at least to take care of the VA part of doing it under that law.

I'm sure Senator Nelson, I assume he's aware of that and will pursue that. But if not, thank you for bringing that to our attention.

Secretary MANSFIELD. We'll notify him. But DOD needs legislation.

Chairman LEVIN. Let me follow that up now. Do you know, Secretary Chu, if DOD has that same power?

Dr. CHU. I don't believe so, sir, but obviously we'd want to doublecheck.

Chairman LEVIN. We'll raise it in the National Defense Authorization bill this year, then. There's no reason why the DOD should not have the same power that VA has to correct mistakes. So my staff I know is following this and we will pursue that, unless, Secretary Geren, do you know whether the DOD has that power?

Secretary GEREN. We looked as hard as we could to figure out a way to address this situation and Army—we looked at it, looked at everything that we had that was discretionary. We could not find a way for it to fit. We went to OSD's lawyers to see if there would be a way to do it at the OSD level. They could not find a way. We kept coming to the same conclusion, that there was a statutory block that kept us from doing it, and we certainly would support an effort to provide the flexibility to redress it.

Chairman LEVIN. Secretary Mansfield, thank you for bringing that to our attention.

Secretary MANSFIELD. Thank my excellent staff here, sir.

Chairman LEVIN. We thank your excellent staff. We appreciate that. We all rely on our staff, more than we like to admit.

There's nobody here who hasn't had a first round, so let me start a second round here. The Senior Oversight Committee has been working diligently on a number of these issues, as we've heard here this morning and were aware of even before this morning. But the question is whether or not the issues that we are discussing will remain a priority over time, talking about transitions and seamless transitions, since there will be a change of administrations in January. What steps are you taking to ensure that these issues will remain a priority during the transition period from this administration to the next?

Secretary Chu, why don't I ask you first and then Secretary Mansfield.

Dr. CHU. We are planning to use—and Secretary Mansfield and I have already begun discussing that issue—the now statutorily chartered JEC, which is a similar partnership between DOD and VA, to make sure that there is no backsliding, no ground lost, no lessening of commitment to these initiatives. We are determined to see them through past the transition using that already existing mechanism.

I think it's already produced, as Secretary Mansfield indicated, important successes in other areas. I point to North Chicago as a prime example of that agenda succeeding, and I'm confident it can carry forward into the next administration.

Chairman LEVIN. Secretary Mansfield?

Secretary MANSFIELD. Sir, one point I would make is that everything that we've discussed that we're putting into action are becoming VA directives that will be on the books as we leave. The other point I would make is in the course of a transition there is normally a discussion with the incoming and the outgoing of the highlights of what the outgoing administration looks at and wants to put in—give their attention to the folks coming in, I'm sure would be a part of this effort.

Chairman LEVIN. Is there a permanent structure, a joint structure that's now in place, to evaluate these changes that we've talked about and to monitor systems and to make further recommendations for process improvement? Is there that structure and if so what is it?

Secretary MANSFIELD. Sir, I would say that, again, the statutorily mandated JEC with its benefits subgroup and its health care subgroup have been working for 5 years now, in an effort to put processes in place that we can measure what is required and be able to make a decision at the end of each year what we've done, what we need to do.

Chairman LEVIN. Now, who are the members of the JEC?

Secretary MANSFIELD. Currently it's myself and Dr. Chu. Secretary Chao from Labor has asked us to include a member from the Veterans Employment and Training Service, which is responsible for veterans employment, and we've agreed to bring somebody from there on board. Then, in the benefits arena, you have the Under Secretary for Benefits from the VA and the equivalent OSD and DOD folks. In the health arena you have the Under Secretary for

Veterans Health and the equivalent folks from the Services in DOD.

Chairman LEVIN. Now, you two are political appointees.

Secretary MANSFIELD. Yes, sir.

Chairman LEVIN. Those under secretaries—are they political appointees as well?

Dr. CHU. They are political appointees.

Secretary MANSFIELD. Yes.

Dr. CHU. But the council, the JEC, is, thanks to your efforts, a statutory body. So whoever succeeds, either acting for or confirmed by the Senate, will succeed to that responsibility. The career staff understands that this agenda has to go forward using this mechanism.

Secretary MANSFIELD. Under secretaries in the VA are political appointees.

Chairman LEVIN. Would you make sure that the career staff not just tells your successors, assuming that you're not reappointed, about this, but that somehow or other, can they be acting during a period that there is a gap?

Secretary MANSFIELD. Sir, the career staff, the leading senior career staff in each agency, are heavily involved in this and understand very well the need for them to be included.

Chairman LEVIN. Are they authorized to meet during a transition period without you?

Secretary MANSFIELD. As part of the JEC?

Chairman LEVIN. Yes.

Dr. CHU. I see no reason why they could not. I don't want to get in the general counsel's way here on the Vacancies Act issue, but I see no reason that those performing the duties of these officials, which would be the last resort, could not in fact convene a meeting.

Chairman LEVIN. Will you let us know whether that can happen?

Dr. CHU. I will do that, sir.

Chairman LEVIN. If it can't happen, let us know what would be required to make that happen legislatively?

Secretary MANSFIELD. We will provide that information, sir.

Chairman LEVIN. That would be great. Thank you.

Secretary Geren, last week you announced a program called the Wounded Warrior Education Initiative. Could you tell us what that's about?

Secretary GEREN. Yes, sir. We announced it at Leavenworth, KS. In September, the chancellor of the University of Kansas came to meet with me and with Dr. Gates to propose an initiative where Leavenworth would partner with Kansas University in developing a graduate degree program for wounded warriors, for specifically wounded warriors. It's a program where the wounded warriors would either stay on Active Duty or, if they have left Active Duty, be supported in some type of an internship role, attend a 2 years master's program at Kansas University, then return to the military and serve in either a teaching capacity or a support capacity at our colleges at Leavenworth.

It is a very innovative program, and we were able to work with Kansas over a period of just several months and pull it together, and last week we announced that we have eight soldiers accepted

into the program; we hope to build on it. I think it's a model that could be used elsewhere.

Chairman LEVIN. Yes, if it works I assume you will expand it.

Secretary GEREN. Yes, sir.

Chairman LEVIN. Now, some have proposed giving veterans a plastic card that they could take to any health care provider to pay for their health care. Can you give us your view on that proposal, Secretary Mansfield?

Secretary MANSFIELD. I don't think it's a good idea.

Chairman LEVIN. Why is that?

Secretary MANSFIELD. The VA is set up to be able to be the primary care provider for the individuals in the system and keep track of what their needs are and follow them throughout the system. Part of what you're looking at is taking us away from that, where we wouldn't know what's going on with the care, what the quality is, what they need, what they don't need.

The other part of it is it would make us in effect a insurer, a Medicare-type payor for the system, and I don't know what kind of a requirement we would have for the back office, that we'd have to replicate the Medicare system to get the bills; figure out what the bills are; whether they were reasonable or not; whether the treatment was reasonable; and then make a payment.

Chairman LEVIN. Do veterans groups generally favor this kind of approach, do you know, or not?

Secretary MANSFIELD. I don't think they do favor it, sir. I think they would look at it as starting to unravel the VA. As was mentioned here earlier, we now have reached a point where we are regarded as providing pretty good care and taking pretty good care of these individuals that are in our system.

Chairman LEVIN. One of you mentioned the electronic health record system which we're trying to develop between the two entities. I've forgotten, was it Dr. Chu? Were you doing it? You made that reference? What's the timetable for that?

Dr. CHU. Sir, we anticipate by the end of this year having all existing electronic information interchangeable—viewable, as I understand the computer community phrase it—between the two institutions, so if you are a VA doctor you can see the DOD record and vice versa. We already have the pharmacy data at that stage. We have the laboratory data to that stage, the first discharge summaries to that stage, et cetera.

It's a very significant project. It's been ongoing for a number of years. The recent Senior Oversight Committee effort has given extra energy to it and I think we'll get to that goal by the end of this year.

It doesn't necessarily make the data, as the computer community would phrase it, computable. In other words, you can't manipulate it inside the program. I can look at it. For that, eventually what we need to do is have a common electronic health record between the two Cabinet agencies, and we are committed to doing that. That is a multi-year project. That's not going to be overnight. It allows us to replace our aging existing inpatient electronic records.

We do have in DOD a worldwide, essentially web-based, although that's not actually the vehicle used; it's on servers that we control, the outpatient electronic record now, which is part of what we're

making available to the VA physicians for outpatient treatment. But we need to modernize our inpatient software, replace it basically. The VA eventually will have the same need. So we are committed jointly. The first exploratory effort has begun getting to that common, essentially identical, electronic health record for the future. But that is a multi-year project.

Chairman LEVIN. If it's an identical record, then each agency would be able to add to that record?

Dr. CHU. Exactly.

Chairman LEVIN. Manipulate the information.

Dr. CHU. Manipulate the information, and DOD's ambition is to mirror for that what we can now already for ourselves do for outpatients, which is wherever you are, at least in theory, I can call up what's been done to you as an outpatient, on an outpatient basis. That's important because our people move around the world so much. So we don't want something that's site specific in character. These data are now on servers that allow worldwide access.

Chairman LEVIN. Did we require that by law?

Dr. CHU. You required in statute that we make it interoperable.

Chairman LEVIN. But not the second step?

Dr. CHU. Not the second step. It's a multi-year project. We will be coming to you in this and future budgets.

Chairman LEVIN. But we haven't already mandated it?

Dr. CHU. I don't believe so, sir.

Chairman LEVIN. You and I both used the word "manipulate" and I think we have to find a different verb.

Dr. CHU. Yes, sir. They like to say "computable."

Chairman LEVIN. Yes. I shouldn't use that word because some people would understand that to be a pejorative word, that we are somehow or another manipulating data for some nefarious purpose.

Dr. CHU. No nefarious purpose intended.

Chairman LEVIN. No, no. I used the word, too. But I don't know what the new verb is. "Computable," is that it?

Dr. CHU. "Computable" is my understanding.

Chairman LEVIN. Make it computable.

Okay. I think Senator Chambliss, yes, Senator Chambliss, you are next.

Senator CHAMBLISS. Thank you very much, Mr. Chairman.

Gentlemen, thank you, first of all for being here, and for your excellent testimony this morning. But thank you for what you do. Thank you for being concerned about our brave men and women who wear the uniform.

Also please convey our thoughts and prayers to the Secretary. Gee, Pete—what did you do to him over there? Rough morning at the Pentagon. Actually, it was pretty slippery in my neighborhood, too. Tell him we're thinking about him.

Let me thank all of you for your efforts over the last year to improve health care and transition programs for our wounded warriors. I've personally seen how the WTUs and our health care professionals have made great strides in caring for and treating our wounded servicemembers. I have been to both Fort Gordon and Fort Benning, where I've seen firsthand what is happening with respect to our men and women who are coming back with injuries.

We are doing a great job of helping them reintegrate into the military and the community, and I appreciate the hard work each of you has done to get us to this point.

I note in Secretary England's statement that he focuses on the recovery coordination program. This program is designed to identify and integrate care and services for wounded servicemembers, veterans, and their families. Establishing recovery coordinators to serve as the patient and family single point of contact during their recovery and transition period was discussed in the number one recommendation of the Dole-Shalala Commission, and I'm pleased to see that the Department is taking steps to implement this very important recommendation.

Training for the recovery coordinators is obviously very important if they are going to perform their jobs effectively. Augusta, GA, has developed a very unique collaboration in the area of wounded warrior care. The City of Augusta is home to the Eisenhower Medical Center at Fort Gordon, formerly operated under the great leadership of General Schoomaker. We miss you there, but your successor General Bradshaw is certainly doing a great job.

What I am going to talk about here and ask you about is something that began under your leadership, and we thank you for your continued attention to the care for our wounded warriors.

It is also home to the Charlie Norwood VA Medical Center and the Medical College of Georgia, particularly the school of nursing. These three institutions are already collaborating in the treatment of wounded warriors and the Charlie Norwood VA Center hosts the only Active Duty rehab facility for military personnel in a VA medical center. The Medical College of Georgia School of Nursing has an existing program for training and certifying clinical nurse leaders. These clinical nurse leaders are basically the civilian equivalent of DOD's wounded warrior recovery coordinators and perform many of the same tasks.

As a means of extending the collaboration and treatment of wounded warriors in the Augusta area, the Medical College of Georgia School of Nursing has proposed a short certificate program which would take advantage of classes and faculty already available in their clinical nurse leader program to help train and certify DOD's recovery coordinators. I understand from the statements of several of you that DOD is conducting some training, including web-based training, for your recovery coordinators. But I'm wondering if you would consider taking advantage of this proposal that the Medical College of Georgia is offering, to determine if it could be an effective means of helping to train your recovery coordinators and if it would provide a value-added addition to the Department's establishment of a wounded warrior recovery program.

I'll direct that to whoever wants to respond first, but Dr. Chu, Mr. Secretary.

Dr. CHU. Yes, sir. We always value new ideas. We'd be delighted to look at this one.

Secretary MANSFIELD. Sir, I would add that it's interesting you mentioned Fort Gordon, because we have at the present time a program with VA and DOD that goes back I think to 2004, where the VA is actually doing rehab for Active Duty soldiers down there. So that cooperative effort is already in place down there, and we can

look at going forward and, as Dr. Chu mentioned, doing something new and better.

Senator CHAMBLISS. Anyone else have a comment? [No response.]

I know that the personnel at the Medical College of Georgia School of Nursing would be willing to modify their proposal in order to meet any specific training requirements, as well as the necessary timeframe that DOD might require for training their recovery coordinators, and whatever will be helpful to the Department and the college from a discussion standpoint. These folks are ready and willing to offer any services necessary.

General Schoomaker, you know firsthand the great job that Dr. Romm and the folks over at the Medical College do, as well as the folks at the VA Medical Center. I've had the pleasure of visiting many of our patients there at the VA Center over the last several years. The work that we are doing, particularly with our severely injured soldiers, is truly amazing there. Thanks again, General Schoomaker, for your leadership and role at Eisenhower in establishing it as certainly the premier in my opinion recovery unit for our wounded warriors out there.

General SCHOOMAKER. Thank you, sir. Frankly, I get the credit for the terrific work of a team at the Augusta VA Medical Center and at Eisenhower. We had a very farsighted group in both communities who recognized very early in the war the nature of the injuries that our soldiers, sailors, airmen, and marines were suffering. The long experience that the Augusta VA Medical Center and many VAs throughout the system have in rehabilitative medicine, especially with blind and deaf and TBI and PTSD, which Secretary Mansfield has talked about already, I think was resident within those communities, and they reached out to us, just as we reached to them, and we continue to have a very collegial and cooperative relationship.

It's important to note that this was built on a relationship of cooperative agreements that go back in neurosurgery, that go back in cardiothoracic surgery between the two organizations, which set the framework for what you have there today.

We really truly appreciate the support that you have given to this, that Senator Isakson has given, that Congressman Norwood, the late Charlie Norwood, gave to it, and now Congressman Broun gives to it.

Senator Inhofe said something earlier that I think is very important and that is that his own—the revelation, the epiphany that he has experienced in going back into the VA system and seeing that this is such a high quality system. That insight, frankly, is one that all of our soldiers and their families need to recognize. Relationships such as we have at the Augusta VA Medical Center, but all our polytrauma units, if you've been to see them, tell us every day as well—it allows our soldiers and families, even if they come back into uniform, fully recovered and rehabilitated, it gives them an insight into what the VA medical system provides for them and much greater confidence through working knowledge of the VA. So these kinds of relationships are just absolutely fundamental.

Thank you, sir.

Senator CHAMBLISS. Thank you, Mr. Chairman.

Chairman LEVIN. Senator Chambliss, thank you.

Senator Warner.

Senator WARNER. Thank you, Mr. Chairman.

The Army really has on its own initiative established this warrior transition brigade. As I understand it, this fine officer was introduced as the brigade commander, is that correct?

General SCHOOMAKER. Yes, sir. He's the first brigade commander for the WTU. Colonel McKendrick is the commander of the only brigade within the WTUs. We have 34 other WTUs at the battalion and company level.

Senator WARNER. They're staffed accordingly to the need in that geographic jurisdiction?

General SCHOOMAKER. Exactly, sir, on a standard Army document that provides staff in accordance with the number of patients and the severity of patients.

Senator WARNER. Then, General, do you find it desirable if Congress were to recognize this in legislation at all? Or do you prefer to just leave it as it is right now?

General SCHOOMAKER. I guess, sir, I need a little clarification as to how Congress wants to recognize it.

Senator WARNER. Well, now, wait a minute. I'm not suggesting that Congress move in. This is an Army initiative.

General SCHOOMAKER. Yes, sir.

Senator WARNER. It's working. You may not need anything in there by Congress. But every now and then organizations need a little structural recognition in the law to stay alive after passage of time and other priorities begin to encroach on Army needs and so forth.

General SCHOOMAKER. Yes, sir. I believe in the National Defense Authorization Act for Fiscal Year 2008 you gave us the right structure and the right imperative, without giving us such directive ratios of soldiers and patients, that we have the latitude to really make the judgments that we need to make, sir.

Senator WARNER. Now, what about your staffing? Are you looking for volunteers to take this on? Is it career-enhancing? As you well know, that has to be somewhere in the residual recesses of every Army mind as he or she is moving up: Is this assignment going to help me move on to my next goal in the Army?

General SCHOOMAKER. Yes, sir. What we have done is, first of all we have codified the units in Army doctrine so that they have all of the necessary administrative tools to have an enduring presence within the Army. We have funded them. The Army has stepped forward very aggressively and put manpower against them. Despite a war and the challenges of deploying soldiers, they have placed 2,500 soldiers against them and these are not traditional medics.

What we see happening is that these positions represent for the cadre that fill those roles an opportunity for them to take a knee from constant deployment or recruiting duties or training duties and other things. We've also put special pays in for the NCO leadership. These are all signs that these are important jobs for the Army, and I think the visibility it's given for the senior Army leadership and the emphasis that the Chief of Staff and the Secretary have given to this I think are all signs of the importance.

Senator WARNER. What about Reserve and Guard members? They will be on equal par?

General SCHOOMAKER. They are, sir.

Senator WARNER. Do you have a quota for so many regular Army and so many who are Army reservists and so forth?

General SCHOOMAKER. Absolutely, sir, to mirror the composition of the WTUs, so guardsmen and reservists are also present there, especially because of the special needs of the Guard and Reserve with respect to administrative and pay and travel issues and the like.

Senator WARNER. Let's go back to the family support, the parents, the spouses, and so forth. Do they have access to this organization to help get support?

General SCHOOMAKER. Oh, yes, sir. Of course, the Army family is one of the cornerstones of the Army. We feel very strongly about the need to support our families. We have created Soldier and Family Assistance Centers at every one of our sites.

Senator WARNER. But is this brigade also part of that infrastructure that the families can access?

General SCHOOMAKER. Oh, absolutely, sir.

Senator WARNER. The wife, parent, can walk right in and say, look, my soldier husband or son is just not able to get here today; I want to try to get this for him, and so forth?

General SCHOOMAKER. Yes, sir. The nurse case managers that are providing administrative oversight of the needs of that soldier I think also provide ingress for that.

Have I depicted that correctly there?

Secretary GEREN. Yes, sir.

Senator WARNER. You're satisfied that the budget and everything else is adequate to help the family members as they try to continue their roles of support for their spouses or sons as the case may be?

General SCHOOMAKER. Yes, sir. As we've identified challenges to these families to travel, for example, or to be there, be present and provide support for a wounded son or daughter or husband or wife, even non-marriage, non-medical attendance, we have reached out to them and have found the necessary funds to support their travel and presence.

Senator WARNER. To our distinguished Secretary of Veterans Affairs, indeed I look back over your personal record of achievements. You've certainly served this Nation well. Thank you for continuing, Secretary Mansfield, in your role today.

Secretary MANSFIELD. Thank you.

Senator WARNER. Have we covered here this morning—some of us in the course of votes missed some testimony—the disability rating for servicemembers, the pilot program? Have you testified about that this morning?

Secretary MANSFIELD. We talked about it generally, sir. The pilot started. It's up and running. We've had the first case run through the system. It'll be running until November and we'll be taking periodic looks at it.

Senator WARNER. So that the record this morning has adequate testimony with regard to that very important program?

Secretary MANSFIELD. I believe so, sir.

Dr. CHU. Yes, sir, I agree.

Senator WARNER. Thank you very much.

How about the improvements in the DOD disability evaluation system? Have we covered that adequately this morning?

Dr. CHU. Yes. That's part and parcel of the same effort.

Senator WARNER. All right. Mr. Chairman, I think you've conducted a very good hearing this morning. I have seen part of it.

Secretary GEREN. Mr. Chairman, could I just make one point in response to Senator Warner?

Chairman LEVIN. Please, Secretary Geren.

Secretary GEREN. When the legislation was being developed for the Wounded Warrior Act there were those, many of them who were in the other body, that did advocate a fairly prescriptive approach to setting ratios and using statutes to set up these WTUs or systems to meet the needs of wounded warriors. We worked with this committee and you gave us the kind of flexibility that we felt was very important for us to be able to shape these units so that they were able to adjust to the dynamic situation that they're asked to work in. We appreciate very much how this committee worked with us and provided us that kind of flexibility.

We think that's one of the success stories in this legislation that you passed—it gives these Army leaders the opportunity to be somewhat entrepreneurial. They did create this in a very short time out of whole cloth, a totally different approach, and they continue to adjust it. They continue to make improvements.

General Schoomaker talked about this task force that he's heading up to look at how we start accommodating the needs of some of these soldiers who are particularly vulnerable, that have all been brought together in these WTUs. He will continue to fine-tune this, as well as General Tucker and the others that are working in the area. So the flexibility that you gave us, I think, is very important as we shape this over the coming years, and we appreciate very much how you've given these great Army leaders the opportunity to be entrepreneurial, to do something that has not been done before. It's a work in progress today, great progress, but a work in progress.

Senator WARNER. The group of Army veterans—actually they're Active Duty—is almost 10,000; is that correct?

Secretary GEREN. Yes, sir. In the WTUs?

Senator WARNER. Yes.

Secretary GEREN. That's Active, Guard, and Reserve, but they're all currently on Active Duty. It's about 9,600 right now.

Senator WARNER. These, they go all the way from where they're still getting treatment to this transition group, trying to integrate them back into the U.S. Army and find an MOS and a responsibility that they can fulfill the Army commensurate with such limitations as they might have as a consequence of their wounds; is that correct?

Secretary GEREN. Yes, both to give them the opportunity and prepare them to return to duty or, if they're going to transition to civilian life, to make sure that they are well-equipped to be productive citizens and anything we can do to prepare them for that.

Senator WARNER. A number of these are accessing health care both within the regular Army and accessing it within the veterans organization; is that correct?

Secretary MANSFIELD. That's correct, sir.

Senator WARNER. You've worked out a system where that can be done.

These are really dramatic changes, Mr. Chairman, in the small period of a year's time. You're to be commended, each and every one of you.

Dr. Chu, in the old Navy we used to get a red hash mark for every couple of years of service. How many years of service have you been coming before this committee?

Dr. CHU. If I include my prior service, with my break in service here, it's getting close to 20 years.

Senator WARNER. 20 years.

Chairman LEVIN. How many Purple Hearts have you been awarded—[Laughter.]

Senator WARNER. For wounds inflicted by Congress. [Laughter.]

Chairman LEVIN. I hadn't finished the sentence, but he got it.

Senator WARNER. That's quite a record, Dr. Chu.

Dr. CHU. Thank you, sir.

Senator WARNER. That's quite a record.

Give your Secretary our best. Tell him you stood in very well for both the Deputy and Secretary Gates. All of us went home on that ice last night. It's an experience. It could happen to anybody.

Chairman LEVIN. Give our best to Secretary Gates. Tell Secretary England we didn't miss him, you did fine. That will make his day, I'm sure.

Secretary Geren, you made reference to flexibility. We did work with you very closely to give you flexibility and I think you and the others understand that that flexibility goes to how you accomplish the requirements, not whether the goal is achieved. I think it was the right thing to do and we're more than happy to work with you, because we think you and the other witnesses and the Department are as determined as we are to get these changes made. So that's what we're relying on. That's what our troops are relying on, and their families.

We thank you for your testimony. We thank the soldiers for their service, for coming here this morning, and their families for the kind of support that they give, which is so essential to these programs working.

With that, we will stand adjourned.

[Questions for the record with answers supplied follow:]

QUESTIONS SUBMITTED BY SENATOR ROBERT C. BYRD

MEDICAL TREATMENT FACILITIES

1. Senator BYRD. Secretary Chu, Public Law 110–28 requires the Department of Defense (DOD) to inspect and develop standards for medical treatment facilities (MTFs), and for medical hold and medical holdover personnel housing. Secretary England's prepared testimony suggests that these standards were developed and the facilities were inspected. When can Congress expect to see a copy of the standards developed by the DOD?

Dr. CHU. The Department already maintains standards for MTFs, and established standards for medical hold/holdover housing in September 2007. The inspections are complete, and the first Department consolidated summary inspection report, which includes a summary of the DOD standards for MTFs and medical hold/holdover housing, will soon be transmitted.

2. Senator BYRD. Secretary Chu, the same legislation required that not later than 180 days after the date of the enactment, which was May 25, 2007, and annually thereafter, the Secretary of Defense shall inspect each facility of the DOD as follows:

Each military MTF; each military quarters housing medical hold personnel; and each military quarters housing medical holdover personnel. Secretary England's prepared testimony states that each facility already has been inspected. Has each facility been inspected to the standards developed by the DOD?

Dr. CHU. Yes. Each of the military Services has completed its inspections to the DOD standards.

3. Senator BYRD. Secretary Chu, were deficiencies noted during these inspections?

Dr. CHU. Due to a substantial commitment of resources over the last year, urgent deficiencies have been corrected; and the inspections found that all MTFs providing care to wounded servicemembers and quarters housing medical hold and medical holdover personnel meet the DOD standards for maintenance and operation.

4. Senator BYRD. Secretary Chu, what were the principal types of deficiencies noted?

Dr. CHU. The primary type of deficiencies noted and corrected concerned accessibility requirements.

5. Senator BYRD. Secretary Chu, when can we expect to begin seeing these reports as required by the law?

Dr. CHU. The DOD's first consolidated summary inspection will soon be transmitted.

6. Senator BYRD. Secretary Chu, given the deficiencies reported last year, has the cost of correcting deficiencies identified during the standards inspections been included in the fiscal year 2009 DOD budget request?

Dr. CHU. With regard to housing for medical hold and holdover personnel, the correction of urgent deficiencies has been funded with the fiscal year 2007 and fiscal year 2008 operations and maintenance (O&M) appropriations. However, the military Services consider much of the current housing for medical hold and holdover personnel to be an interim solution. Accordingly, the President's fiscal year 2008 military construction budget request included two new wounded servicemember barracks for the Marine Corps at Camp Pendleton, CA, and Camp Lejeune, NC. The Department is grateful for congressional support and approval of these important projects. The President's fiscal year 2008 global war on terror military construction budget request included seven Army Medical Action Plan (AMAP) projects, two of which had Warrior in Transition (WT) barracks: Fort Riley, KS, and Fort Drum, NY. The Department is assessing the need for additional AMAP military construction projects in future budget requests.

Regarding MTFs, the correction of urgent deficiencies has been funded with fiscal year 2007 and fiscal year 2008 O&M appropriations. The inspections did not include a comprehensive assessment of the aging environments at these MTFs and how they compare to those of civilian world class facilities. The Department is assessing the need for additional medical military construction projects in future budget requests to provide world class healing environments in a new era of health facilities that improve clinical outcomes, patient and staff safety, and operational efficiencies. The President's fiscal year 2008 global war on terror budget request did include funding to accelerate construction and enhance clinical capabilities in support of our wounded servicemembers at the new Walter Reed National Military Medical Center, Bethesda, MD, and new Fort Belvoir Community Hospital, VA. It also included a Burn Rehabilitation Center project for our wounded servicemembers at the new San Antonio Military Medical Center, TX.

7. Senator BYRD. Secretary Chu, in the development of standards for the maintenance and operation of military medical facilities, Congress intended to ensure that military medical facilities meet generally acceptable standards for the maintenance and operation of such facilities or quarters, as the case may be; and, where appropriate, standards under the Americans with Disabilities Act of 1990; and that they be developed at the earliest date practicable to ensure that our service men and women receive the care they have earned.

Please explain the nature of concrete progress made in meeting these requirements, and, again, when can Congress begin to see the routine flow of reports from the medical services of the DOD detailing deficiencies as well as steps that the DOD is taking to correct them?

Dr. CHU. The DOD already maintains standards for MTFs, and DOD established standards for medical hold/holdover housing in September 2007. The inspections are complete, and the Department's first consolidated summary inspection report, which

includes a summary of DOD standards for MTFs and medical hold/holdover housing, will be submitted to Congress shortly.

The Department made a substantial commitment of resources over the last year to correct urgent deficiencies (mostly to meet accessibility requirements). The inspections found that all MTFs providing care to wounded servicemembers, and quarters housing medical hold and medical holdover personnel meet DOD standards for maintenance and operation. If further inspections reveal any major deficiencies, the reports will be submitted in accordance with the National Defense Authorization Act for Fiscal Year 2008 (Public Law 110–181), sections 1648 and 1662.

QUESTIONS SUBMITTED BY SENATOR JOSEPH I. LIEBERMAN

BEHAVIORAL HEALTH PROVIDERS

8. Senator LIEBERMAN. Secretary Geren, the shortage of behavioral health care providers in the United States is well-documented, in both the military and civilian sectors. However, the acute mental health needs of many servicemembers are exacerbating the shortages of uniformed behavioral health providers within the DOD. In turn, this shortage poses a significant barrier to adequately addressing problems with identification of mental health problems, such as Post-Traumatic Stress Disorder (PTSD), and access to appropriate Services. I am currently working with Senator Boxer to introduce legislation that ensures that each of the Services has the necessary financial incentives to recruit and retain uniformed behavioral health providers, which are especially critical given our current deployment and stateside behavioral health needs. Are there specific authorizations that the Department currently does not have, but that would assist, in recruiting and retaining uniformed behavioral health professionals?

Secretary GEREN. The passage of the National Defense Authorization Act for Fiscal Year 2008, specifically section 661 (Consolidation of Special Pay, Incentive Pay and Bonus authorities of the Uniformed Services), provides a degree of flexibility which will be helpful. Section 661 appears to provide sufficient authority to institute the recruitment and retention programs, and we will work with the DOD to implement them. We will need to evaluate these programs as they progress. If our analysis indicates that the new legislative authorities are not effective, we will work with Congress to develop additional solutions.

9. Senator LIEBERMAN. Secretary Geren, what steps has the Department taken to retain uniformed behavioral health providers in each Service and what analyses have been conducted to determine how many additional uniformed Service providers are needed?

Secretary GEREN. The Army has received authorization for and implemented the Critical Skills Retention Bonus (CSRB) for Clinical Psychologists at a rate of $13,000/year for 2 years or $25,000/year for 3 years. Additionally, the Health Professions Loan Repayment Program is available for the retention of 20 Clinical Psychologists and 20 Social Workers at the current rate of $38,437 per year. Social Workers in the grade of captain are eligible for the Army CSRB at the rate of $25,000 for a 3-year Active Duty service obligation. Psychiatrists who execute a multi-year special pay contract (extending their Active Duty service obligation) are paid at the rates of $17,000/year for a 2-year contract, $25,000/year for a 3-year contract and $33,000/year for a 4-year contract.

The Army performs regular force management analyses of operational forces as part of the Total Army Analysis. In Theater, the Army has taken the additional step of reviewing the quantity and distribution of mental health assets as part of the annual Mental Health Advisory Team (MHAT) assessments. The Army uses the Automated Staffing Assessment Model (ASAM) to determine appropriate staffing requirements in our military treatment facilities (MTFs). Our manpower experts significantly revised the ASAM 2 years ago to reflect the additional psychological stresses on soldiers and their families as a result of the war. This revision led to increased requirements for behavioral health providers. Additionally, in the spring of 2007 the Army Medical Command queried each MTF to identify shortfalls in behavioral healthcare staffing requirements. This afforded hospital commanders the opportunity to validate ASAM-recommended levels or identify additional needs.

10. Senator LIEBERMAN. Secretary Geren, given deployment needs, to what extent is the Army focused on recruiting and retaining uniformed behavioral health professionals rather than civilian providers?

Secretary GEREN. We are equally focused on recruiting and retaining both uniformed and civilian providers. The military and civilian mix within the Army's behavioral health community is the result of many deliberate processes. The military authorizations present in our deploying units are carefully developed, reviewed, and codified in our Tables of Organization and Equipment. The military authorizations in our fixed facilities are also derived by a deliberate process. To focus on military or civilian providers to the detriment of the other is unhealthy for our total team. We continue to pursue all actions to recruit and retain to 100 percent of our military authorizations while at the same time recruiting and retaining civilians.

MILITARY TREATMENT FACILITIES

11. Senator LIEBERMAN. Secretary Chu, my staff has been traveling to military installations across the country to assess medical and behavioral health needs and resources in the system. It is evident from their visits that there is a growing strain on our military health care system. In particular, the reduction in uniformed health care providers appears to be placing a distinct strain on the military health care system because of the dual deployment and stateside staffing requirements within MTFs of personnel. This appears to have created an overreliance in many specialties on contracted providers.

What models has DOD and each of the Services used in determining uniformed, government service, and contractor staffing requirements for MTFs? Have these models been adjusted for peacetime and wartime requirements, and for the demographic changes in the forces?

Dr. CHU. Service and local level medical administrators apply models that work best for their settings, mission requirements, and available military and local assets.

A recent DOD-level initiative developed a specific model for staffing of mental health providers across the Services that is currently being validated by the Center for Naval Analyses. This population- and risk-based model accounted for multiple factors in making recommendations for the number and types of mental health providers at MTFs. The specific factors included:

- number of Active Duty (AD) members
- number of family members and percentage that use military providers
- number of other eligible beneficiaries
- number of individuals at an MTF with a diagnosis of PTSD
- average number of mental health (MH) visits per year of those with PTSD diagnoses
- number of AD members to be deployed in the next year
- number of accredited psychology training programs in MTFs in the area
- number of accredited psychiatry training programs located in MTFs in the area
- number of MH techs assigned to inpatient psychiatric units
- number of MH nurses assigned to inpatient psychiatric units
- number of social workers primarily assigned to inpatient psychiatric units
- number of psychologists assigned to inpatient psychiatric units
- number of psychiatrists primarily assigned to inpatient psychiatric units

12. Senator LIEBERMAN. Secretary Chu, what proportion, Department-wide and for each of the Services, of the health care work force is comprised of General Schedule employees, contractors, and uniformed providers? How do the proportions differ from previous years?

Dr. CHU. We have sound data on government civil servants and uniformed personnel. Contractors are locally controlled and based on budget so, although we suspect an increase of contractor full-time equivalents (FTEs) we do not have reliable centralized numbers. The proportion of government civil servants has increased from 26 percent to 30 percent. At the same time, the combined numbers have gone from 156,609 to 156,409.

Proportion of Active Duty (AD) Military Medical to Defense Health Program (DHP) Civilian FTEs

	Fiscal Year (FY) 2002	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007
DoD AD	116,103	117,914	119,117	116,200	116,485	110,260
DoD Civilian	40,506	41,942	41,853	42,013	43,246	46,149
Total	156,609	159,856	160,970	158,213	159,731	156,409
DoD AD	**74%**	**74%**	**74%**	**73%**	**73%**	**70%**
DoD Civilian	**26%**	**26%**	**26%**	**27%**	**27%**	**30%**

Notes:
1. AD military personnel are actual on board across entire Department as of September 30, 2007
2. Number of DHP Civilian FTEs reported only for those working in military health system fixed facilities as of September 30, 2007
3. Number of Civilian FTEs include both medical and non-medical personnel funded by the DHP

13. Senator LIEBERMAN. Secretary Chu, how has core funding to staff MTFs been allocated, Department-wide and for each of the Services, to support uniformed providers, General Schedule employees, and contractors?

Budget Activity Group 1 - In-House Care - Total Obligations ($000s)

	Fiscal Year (FY) 1998	FY 1999	FY 2000	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007	FY 1998-2007
Army	1,554,628	1,568,421	1,716,501	1,861,465	2,080,832	2,340,514	2,570,716	3,092,826	3,365,059	3,600,997	131.6%
Navy	902,502	895,786	916,496	1,039,222	1,159,600	1,204,930	1,319,869	1,609,179	1,783,487	1,864,478	106.6%
Air Force	893,584	930,530	935,937	1,017,391	1,143,722	1,218,518	1,288,554	1,557,619	1,665,250	1,799,651	101.4%
Total	3,350,714	3,394,737	3,568,934	3,918,077	4,384,154	4,763,962	5,179,138	6,259,624	6,813,796	7,265,126	116.8%

Budget Activity Group 1 - In-House Care - Contract Obligations ($000s)

	FY 1998	FY 1999	FY 2000	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007	FY 1998-2007
Army	333,772	315,587	340,958	333,547	282,689	351,736	382,834	648,740	711,844	732,456	119.4%
Navy	233,904	157,213	134,411	134,390	181,800	223,448	251,734	373,395	458,121	488,631	108.9%
Air Force	100,404	115,528	94,463	48,996	78,271	98,998	90,998	263,740	374,987	506,968	404.9%
Total	668,080	588,328	569,833	516,933	542,760	674,183	725,566	1,285,874	1,544,952	1,728,055	158.7%

Contract Obligations as a Percentage of Total In-House Care Obligations

	FY 1998	FY 1999	FY 2000	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007
Army	21.5%	20.1%	19.9%	17.9%	13.6%	15.0%	14.9%	21.0%	21.2%	20.3%
Navy	25.9%	17.6%	14.7%	12.9%	15.7%	18.5%	19.1%	23.2%	25.7%	26.2%
Air Force	11.2%	12.4%	10.1%	4.8%	6.8%	8.1%	7.1%	16.9%	22.5%	28.2%
Total	19.9%	17.3%	16.0%	13.2%	12.4%	14.2%	14.0%	20.5%	22.7%	23.8%

Budget Activity Group 1 - In-House Care - Civilian Pay Obligations ($000s)

	FY 1998	FY 1999	FY 2000	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007	FY 1998-2007
Army	707,653	738,324	793,401	830,922	905,048	994,001	1,075,873	1,175,255	1,299,759	1,404,664	98.5%
Navy	234,676	256,866	274,807	284,970	291,513	312,182	329,406	347,372	405,324	454,744	93.8%
Air Force	201,159	199,507	198,823	196,555	205,236	217,515	223,475	225,641	236,666	259,170	28.8%
Total	1,143,487	1,194,698	1,267,031	1,312,448	1,401,797	1,523,699	1,628,754	1,748,267	1,941,749	2,118,578	85.3%

Civilian Pay Obligations as a Percentage of Total In-House Care Obligations

	FY 1998	FY 1999	FY 2000	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007
Army	45.5%	47.1%	46.2%	44.6%	43.5%	42.5%	41.9%	38.0%	38.6%	39.0%
Navy	26.0%	28.7%	30.0%	27.4%	25.1%	25.9%	25.0%	21.6%	22.7%	24.4%
Air Force	22.5%	21.4%	21.2%	19.3%	17.9%	17.9%	17.3%	14.5%	14.2%	14.4%
Total	34.1%	35.2%	35.5%	33.5%	32.0%	32.0%	31.4%	27.9%	28.5%	29.2%

Budget Activity Group 1 - In-House Care - Civilian Full Time Equivalents (FTEs) (Direct and Reimbursable)

	FY 1998	FY 1999	FY 2000	FY 2001	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007	FY 1998-2007
Army	18,623	17,384	17,621	17,928	18,203	19,040	19,184	19,869	20,635	21,637	16.2%
Navy	6,199	6,487	6,396	6,329	6,302	6,346	6,245	6,228	6,575	7,075	14.1%
Air Force	5,287	5,029	4,777	4,645	4,572	4,675	4,460	4,323	4,385	4,654	-12.0%
Total	30,109	28,900	28,794	28,902	29,077	30,061	29,889	30,420	31,595	33,366	10.8%

14. Senator LIEBERMAN. Secretary Chu, to what extent has the medical system utilized recalled retirees?

Dr. CHU. The Services medical systems are all utilizing voluntary retiree recall but none have used involuntary retiree recall. Voluntary retiree recall has been used predominantly for senior individuals who are in key positions, clinical or administrative, and facing mandatory retirement. The numbers are small with the Army using the most, 165 since 2004.

15. Senator LIEBERMAN. Secretary Chu, would it be beneficial to extend the period of time for which they could voluntarily serve after being recalled to alleviate health care workforce shortages?

Dr. CHU. Individuals under voluntary retiree recall serve to support contingency operations in which the Secretary of the Service authorizes the recall. Retired soldiers are only mobilized for Active Duty to support a national emergency and the build-up of forces when personnel requirements cannot be met using Active personnel, National Guard, or Reserve Forces. The mobilization and recall of retired soldiers normally requires the approval of the Secretary of the military department. When the campaign ends, the recall will be ended. Most retiree recalls during this contingency have committed to serving for 2 years. At the end of that tour, some have extended. We have not had problems related to tour lengths being too short.

WARRIOR TRANSITION UNITS

16. Senator LIEBERMAN. General Schoomaker, I recently learned about your efforts to investigate a series of deaths that have occurred in warrior transition units (WTUs), which you believe may be related to drug and/or alcohol overdoses. Many of the young men and women assigned to WTUs are convalescing after serious physical and psychological injuries, and are not only using prescription drugs, but also abusing them in conjunction with other substances, such as illegal drugs and alcohol. The WTUs are already playing a critical role in efficiently addressing the needs of servicemembers with significant injuries. However, their work is especially complicated because, in many cases, they serve a high-risk population because of the nature and complexity of the injuries; therefore, I applaud your efforts to examine this issue further and then to put into place necessary safeguards to address any problems that may be uncovered. How will the investigation be conducted?

General SCHOOMAKER. The Army established a cross-functional Tiger Team consisting of psychologists, psychiatrists, physicians, pharmacists, nurses, safety experts, criminal investigation agents, WTU commanders, first sergeants, and sergeants major to examine the soldier deaths that have occurred in WTUs. First, the team reviewed every Serious Incident Report since June 2007 and catalogued all WT deaths and serious incidents. The team identified 12 deaths and 29 incidents that merited further review through root cause analysis and a four-step risk management process.

Step One—Risk Identification—analyzed and identified sources of risk.

Step Two—Risk Assessment—assessed risk in terms of severity of impact, likelihood of occurring, and controllability.

Step Three—Risk Response Development—developed strategies to reduce possible damage and developed contingency plans.

Step Four—Risk Response Control—implemented risk strategies, monitored and adjusted the plan for new risks, and instituted changes.

Team members aggregated findings and recommendations from the risk management review and assembled a list of recommendations designed to protect soldiers and further reduce the likelihood of serious incident. I received an interim report on February 12, 2008, from the Tiger Team, with recommendations for 71 initiatives. The team is already implementing 18 of the initiatives and is continuing to address concerns related to deaths and serious incidents in our WTUs.

17. Senator LIEBERMAN. General Schoomaker, what safeguards do you anticipate may need to be put in place?

General SCHOOMAKER. The Tiger Team recommended 71 initiatives in their interim report, including 18 that could be implemented on or about March 3, 2008. Some of these actions include the following:

- Create an alcohol-free zone around WTU billets and on-post lodging facilities to ensure that WTs do not consume alcohol within their barracks rooms.
- Conduct a risk assessment for each WT to determine those at high risk. Each assessment is individualized and considers input received from the primary care manager (PCM), nurse case manager, squad leader, as well as other WTU staff and health care professionals.
- Annotate a "no alcohol" order on a soldier's physical profile when the PCM determines that consumption of alcohol poses unacceptable risk to a soldier due to a particular medical condition and/or medication regimen. The soldier's WTU commander counsels the WT in writing that he or she is prohibited from consuming alcohol.
- Link pharmacy support to each WTU for consultation and training on the dangers of abuse.
- Conduct family and social support assessments during in-processing and during weekly nurse case manager contacts in order to determine and document in each WT's medical record potential broken relationships.
- Coordinate and identify a location to store privately-owned weapons.
- Review each WT's pay to determine if there are any indicators of financial stress or similar issues.
- Ensure that each WT and their family received a reintegration briefing as part of the soldier and family orientation.
- Educate all VIP escorts, family, and staff on the risks associated with providing alcohol to WTs who are on medications.
- Train all platoon sergeants and squad leaders, as well as other WTU staff as directed by the WTU commander, in Cardio-Pulmonary Resuscitation (CPR) and provide pocket masks and gloves.

Additional initiatives are being developed and will be implemented in a phased manner by May 15, 2008, and August 15, 2008, to create the most secure environment possible to protect WTs and their families.

18. Senator LIEBERMAN. General Schoomaker, are substance abuse services working closely in conjunction with WTUs in all locations?

General SCHOOMAKER. The Army is currently evaluating ways to improve the communication capabilities between Army OneSource and MTFs and WTUs in order to better serve WTs and their families. The AMAP addresses substance abuse services as a primary responsibility of the Soldier Family Assistance Centers operated by the Army's Installation Management Command (IMCOM). IMCOM also operates the Army OneSource website where soldiers can seek and obtain assistance and referral for substance abuse.

19. Senator LIEBERMAN. General Schoomaker, can you describe how WTUs work in concert with the substance abuse programs?

General SCHOOMAKER. Key to the success of managing care and support for WTs and their families is the Comprehensive Care Plan which is developed for each WT and managed by the members of the care triad. The Comprehensive Care Plan includes critical care functions of psychosocial assessment, addiction therapy, and behavioral health treatment for WTs. Additionally, WTU staff includes social workers who provide further support for soldiers and their families. Resources are also available through the local MTF and the Army Medical Command to address any substance abuse needs.

20. Senator LIEBERMAN. General Schoomaker, what other challenges can you identify in standing up the WTUs?

General SCHOOMAKER. The most significant challenge in establishing WTUs is the recruitment, assignment, and development of a fully-trained and committed staff for all 35 WTUs. It has taken a great deal of effort over a short timeline to ensure that each and every member of the WTU staff understands the unique demands and challenges caring for wounded, ill, and injured soldiers requires, as well as possessing the courage, commitment, compassion, and dedication required to meet these challenges. The Army Medical Department remains committed to meeting these challenges by providing the resources, facilities, and training that WTU staff, WTs, and their family members require to recover, rehabilitate, and reintegrate either to continued military Service, or as veterans prepared to be productive and successful citizens. In addition to the ongoing challenge of sustaining and improving this program, there remains a requirement to fund and complete necessary construction of accessible housing, adequate administrative facilities, and Soldier Family Assistance Centers, all developed in close proximity to each other and to the MTF to create Warrior Transition Complexes. These complexes will provide WTs and their families ease of access to the care and support they require.

QUESTIONS SUBMITTED BY SENATOR DANIEL K. AKAKA

VETERANS AFFAIRS CLAIMS

21. Senator AKAKA. Secretary Mansfield, I recently introduced legislation which would establish a presumption in the Veterans Affairs (VA) claims adjudication process for combat experience. Among other things, this bill is designed to reduce delays in the disability adjudication process. I understand that VA currently has an ongoing process to address this issue. Please provide details on what the VA is already doing.

Secretary MANSFIELD. 38 U.S.C. § 1154(b) currently enables "any veteran who engaged in combat with the enemy" to show service connection for an injury or disease using only lay evidence. The United States Court of Appeals for the Federal Circuit has held that "[t]he statute does not provide a relaxed standard of proof for determining whether a veteran engaged in combat." Rather, according to the Court, a veteran must first establish that he or she engaged in combat with the enemy in order for a veteran to be able to show service connection for an injury using only lay evidence under 38 U.S.C. § 1154(b). The VA therefore does not have an ongoing process, other than case-by-case adjudications, to address proof of combat for purposes of section 1154(b).

With regard to claims for service connection for PTSD, the veteran's testimony alone establishes the occurrence of the claimed in-service stressor if the evidence of record confirms the veteran engaged in combat or was a prisoner of war. VA considers the receipt of certain individual decorations as evidence of exposure to combat-related stressors. In addition, on January 23, 2008, the Compensation and Pension Service instructed field offices that, if a veteran was diagnosed with PTSD while on Active Duty, that diagnosis is sufficient to warrant an examination for the condition without additional preliminary development.

22. Senator AKAKA. Secretary Mansfield, in 1998, VA and DOD signed a memorandum of agreement (MOA) to implement a common physical examination. In 2003, the President's Task Force for Improving Health Care Delivery recommended that all servicemembers upon separation receive a physical accepted by both VA and DOD. Where are DOD and VA on this matter?

Secretary MANSFIELD. The 1998 MOA between VA and the DOD was for a cooperative single separation exam at VA benefits delivery at discharge sites. If a servicemember decides to file a claim for VA disability and is also required to undergo a military separation physical, then only one exam is performed and VA's protocols are used.

In November 2004, VA and DOD signed another memorandum of understanding (MOU) to implement the single cooperative exam. To date, 130 military installations are covered by this agreement. A new pilot program that began on November 26, 2007, in the National Capital Region further uses the single cooperative examination in the disability evaluation system (DES), for servicemembers undergoing the medical evaluation board/physical evaluation board (MEB/PEB) process. DOD will use this program to determine fitness for continued military Service, and VA will use the program to determine Service-connected disabilities and their severity for purposes of compensation. In the pilot, DOD accepts the tentative VA assigned eval-

uations for purposes of determining entitlement to severance pay or disability retirement.

NATIONAL GUARD AND RESERVE MEMBERS

23. Senator AKAKA. Secretary Chu, the recent report of the Commission on the National Guard and Reserves discussed how best to provide transition assistance to members of the Guard and Reserves during the demobilization process. The Commission's report embraced the Yellow Ribbon Reintegration program pioneer by the Minnesota National Guard. The 2008 National Defense Authorization Act (NDAA) authorized DOD to administer this program for all National Guard and Reserve members and their families. I understand the timeline for this program is in conflict with current policy for when returning Guard and Reserve have their first drill. What is being done to eliminate this conflict, implement this program, and to improve the transition process for members of the Guard and Reserve?

Dr. CHU. The Department is committed to supporting National Guard and Reserve members and their families throughout the deployment cycle. The DOD already has pilot programs in 15 States that provide services and support to Reserve component members and their families, and plans to expand the program to all 54 States and territories. The Department plans to establish the Office for Reintegration Programs within the near future, and has already begun establishing the Advisory Board, and identifying key staff for this office and the Center for Excellence.

Regarding the policy restriction on performing inactive duty training immediately following demobilization, the Department is revising the policy to allow the Services to require demobilized members to participate in reintegration training and activities.

SCREENING FOR SERVICEMEMBERS

24. Senator AKAKA. Secretary Chu, VA is currently screening all returning veterans who seek treatment with VA to see if they may have experienced a traumatic brain injury (TBI). Shouldn't such a screening be done for all returning servicemembers during the demobilization process?

Dr. CHU. All servicemembers, including the Guard and Reserve component, complete assessments when returning from deployments. The Post-Deployment Health Assessment (PDHA) is required within 30 days of returning from deployment and the servicemembers complete the Post-Deployment Health Reassessment (PDHRA) 90–180 days after returning from deployment. During these assessments, servicemembers answer questions where they can identify possible TBI experiences and discuss the experiences with a health care provider.

The DOD and VA jointly developed the set of TBI screening questions. The DOD/VA Joint Executive Committee mandated that the same set of questions be used by both agencies. DOD developed new PDHA and PDHRA forms with these TBI screening questions. The new forms were officially published on September 11, 2007. Since then, the Services have worked hard to modify their respective electronic data collection systems. They finished this work in late December. In addition, the Armed Forces Health Surveillance Center (AFHSC), which is the repository for the electronic forms, has successfully tested data feeds from the Army, Air Force, and Navy systems. No problems were identified.

Now that the technical solutions are operational, the Services will start using the new forms for health assessments. The exact starting dates will vary with each Service. To ensure a smooth and timely start, a policy memorandum establishes a 60-day implementation phase during which AFHSC will accept both the old and new versions of the forms.

Meanwhile, the Services have been encouraged to start using the new versions of the forms immediately rather than wait for the formal announcement of what they already know is necessary. The Army plans to start selected pilot tests of the new forms before April 1, 2008. The Navy, Air Force, and Coast Guard will all start using the forms in March 2008.

25. Senator AKAKA. Secretary Chu, during a recent Senate Veterans' Affairs Committee hearing, testimony was heard that servicemembers returning from Operation Iraqi Freedom (OIF)/Operation Enduring Freedom (OEF) who answer questions on the PDHA related to PTSD or TBI in the affirmative run the risk of being denied post-deployment leave.

How do we get servicemembers to answer these questionnaires honestly, without being concerned about the inability to go on leave?

Dr. CHU. Any time we ask people questions about their health, there is always a chance that they may need an urgent evaluation. However, delays such as you describe are exceedingly uncommon. Most of the PDHAs are accomplished before the servicemembers leave the theater of operations. A health care provider determines whether any urgent evaluation is necessary. Urgent referrals are highly unusual, unless the individual expresses a serious intent to hurt themselves or someone else. The examples you mention, PTSD and TBI, would not fit in this category. Those diagnoses merit prompt follow-up, which can be accomplished after the servicemember returns home. The large units returning from the theater are normally busy with various demobilizing tasks for several days before the individual members disperse to their homes. This allows plenty of time for urgent referrals to be handled on-site, or for education and reassurance to be provided to those who can safely follow up later on. There will always be some people who choose to answer these questions inaccurately, despite all the evidence to the contrary and the reassurances given during the assessment itself. It is clear that most people do not fall into this category based on the number of positive responses we see on the PDHA forms, both those accomplished in theater and those completed at the demobilization sites.

WOUNDED SERVICEMEMBERS

26. Senator AKAKA. Secretary Mansfield and Secretary Chu, I remain concerned that VA and DOD do not have a common definition for which servicemembers are seriously injured, wounded, and ill. What is the operational definition that is being applied in deciding which servicemembers will be considered for assignment to a VA Federal Recovery Care Coordinator?

Secretary MANSFIELD. Within 3 days of admission to a MTF, a multidisciplinary team reviews the servicemember's case using the following criteria to determine if assignment to the Federal recovery care program is in order:

- In acute care at MTF
- Diagnosis of spinal cord injury, burn, amputation, visual impairment and/or TBI/PTSD
- At risk because of psychological complications (psychological and family assessment)
- Patient self-referral based on ability to benefit
- Command referral based on ability to benefit

These criteria are applied without regard to Active component/Reserve component status. No one will be denied entry into the Federal recovery care program.

Dr. CHU. Eligibility criteria for wounded, ill, or injured enrollment into the Federal Recovery Coordinator Program for Active and Reserve personnel serving on Active Duty includes the following conditions: (1) being treated in an acute care setting within a MTF and expected to receive greater than or equal to 30 percent military Service disability rating; (2) diagnosed or referred with one or more of the following conditions: spinal cord injury, burns, amputation, visual impairment, TBI, and/or PTSD; (3) considered at risk for psychosocial complications (identified through psychosocial and family assessment); (4) self-referral based on perceived ability to benefit from a Federal Individual Recovery Plan (FIRP), or Command referral based on ability to benefit from a FIRP. The basis of the origin of a wound, illness, or injury is not a discriminator for enrollment in the FIRP.

POST-DEPLOYMENT HEALTH REASSESSMENT

27. Senator AKAKA. Secretary Mansfield and Secretary Chu, the Government Accountability Office (GAO) recently released a report on the effectiveness of the Post-Deployment Health Reassessment (PDHRA) for members of the Guard and Reserve. I am concerned that those who are in units of less than 60 personnel or who are individually deployed may not be getting appropriate attention. What steps are being taken to ensure that any identified medical needs of this population are being met through either DOD or VA?

Secretary MANSFIELD. The VA has been an active partner in working with Reserve and National Guard Units on the PDHRA initiative since the pilot began in November 2005. All Reserve and National Guard servicemembers returning from deployment are required to participate in the PDHRA screening 90–180 days post-deployment. VA medical centers and veteran centers provide either on-site staff support or PDHRA event assistance for all Reserve and National Guard servicemembers referred from a PDHRA screening event. This includes those referred from remote/rural areas. VA and veteran center staff have participated in PDHRA events

held in Guam, American Samoa, Virgin Islands, and Puerto Rico, along with rural areas across the continental United States.

The VA has had a strong partnership alliance since late 2005 with the National Guard Bureau's transition assistance advisors (TAAs) based at all National Guard Headquarters. VA has been involved in training and ongoing coordination activities for the TAAs, who are based in all 50 States as well as Puerto Rico, Virgin Islands, Guam, and the District of Columbia. The TAAs work closely with local VA medical centers and vet centers to assure that referral linkages are in place between VA and National Guard Units to include those located in remote/rural areas.

Readjustment Counseling Service has robust outreach initiatives in place covering remote/rural settings. Coverage of Reserve and National Guard units are critical components of their outreach efforts.

Dr. CHU. The DOD carefully designed the PDHRA program to include a variety of options just for the reason you mentioned. The Department always recognized that it would be much more difficult to reach out to smaller units or individuals. This is precisely why we established a call center, so that it would be available for anybody, anywhere, anytime. The attention provided by the call center is the equal of what occurs during on-site visits in all respects. The only difference is that the servicemember speaks to a health care provider on the phone rather than across a desktop. The Department recognizes that some people are critical of this lack of a face-to-face interaction. However, there are many people who are more comfortable and honest, discussing sensitive topics like mental health concerns, over a phone with someone who is far away and who cannot be seen. This is simply another variation of telemedicine, which has been shown to be very effective in several health fields. The call center has been highly successful and a desired method, assessing more than 7,000 servicemembers in January 2008 alone.

The call center also makes follow-up calls to see if the servicemembers who received referrals from either an on-site or telephonic assessment obtained an appointment. If not, the call center staff offers to help the servicemember. In addition, DOD has contracted with Vanderbilt University to perform a formal process evaluation of the various ways we accomplish PDHRAs, such as comparing the success of the call center compared to on-site team visits.

The Department has decreased the threshold for the number of servicemembers required to qualify for an on-site team from 60 to 40. This was possible through thoughtful reengineering of the traveling team members' skill sets and other process revisions that increased scheduling flexibility and allows us to send teams to smaller units than before. This combination approach allows us to reach most units with on-site teams, if that is what the commander would prefer, with the call center available as an effective alternative for the rest of the units.

TRANSITION ASSISTANCE

28. Senator AKAKA. Secretary Chu, I understand last August DOD released a memo to the Services expressing Secretary Gates' commitment to increase participation by demobilizing Guard and Reserve personnel in the Transition Assistance Program (TAP) and Disabled Transition Assistance Program (DTAP) to 85 percent. Where is DOD on implementing the Secretary's guidance?

Dr. CHU. The Department is working aggressively to ensure that the Active and Reserve components are prepared and equipped to meet the 85 percent target to which the Secretary has committed. The Department is reviewing current transition assistance materials and delivery techniques by the Services, the Department of Labor (DOL) and the VA to determine where technology and the latest learning methodologies can enhance the learning experience. Through technology, the support material for transition assistance can be more accessible globally to the servicemembers, their families, the Service providers, and the commands.

As a result of the memo noted above (attachment 1), meetings were held with the Service Assistant Secretaries for Manpower and Reserve Affairs to survey what each of the Services was already doing to meet this goal and to address how they would ensure each of their Services did fully comply.

As an outcome of that session, the Department established the TAP Executive Steering Committee (attachment 2), which consists of a senior DOD, DOL, and VA panel that includes the Department's Deputy Under Secretary for Military Community and Family Policy, the Deputy Assistant Secretaries of each of the Services, as well as the Guard and Reserves, and senior officers who have had field operational experience. The Steering Committee's charter is to determine what needs to be done, and then establish an overarching plan to support and implement the pro-

grams and procedures determined by the Executive Steering Committee needed to attain the 85 percent commitment.

To ensure Reserve component involvement is a part of this effort, the Department released a memo (attachment 3) to the Services and to senior Guard and Reserve Commanders, to encourage their subordinate commanders to strongly support and aggressively market this effort through Guard and Reserve family support networks and service organizations to all Guard and Reserve members and their families.

So that Guard and Reserve commanders are successful in this effort, DOD is prepared to send mobile training teams to premobilization and demobilization sites, or to State and local Guard and Reserve units that request assistance in training their personnel on how to access programs and information applicable to benefits and support functions. The mission and scope of the Guard- and Reserve-centric Mobile Training Teams is provided in attachment 4.

The Army has linked the Turbo Transition Assistance Program (TurboTAP.org) Web site to their Army Career and Alumni Program (ACAP) On-Line Home page. ACAP counselors inform servicemembers during preseparation counseling about TurboTAP and encourage them to register with the Web site. Mobilized Reserve component servicemembers who are severely wounded or injured while on Active Duty are reassigned to the wounded WTU.

In a February 26, 2008, memo to all wing commanders, the Air Force Reserve Command strongly encouraged eligible reservists and their families to use the TAP and DTAP. The memo provides primary points-of-contact for TAP and DTAP, which are the Airman and Family Readiness Directors or Liaisons. Family Readiness personnel are maximizing their marketing efforts of this extremely important program to all reservists and their families.

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PERSONNEL AND READINESS

AUG 2 4 2007

MEMORANDUM FOR ASSISTANT SECRETARY OF THE ARMY (M&RA)
ASSISTANT SECRETARY OF THE NAVY (M&RA)
ASSISTANT SECRETARY OF THE AIR FORCE (M&RA)

SUBJECT: Command Support for the Transition Assistance Program (TAP)

As we discussed August 6, as required in PL 101-510, we have a business imperative to ensure that the transition needs of our departing personnel are fully addressed. More specifically, Secretary Gates pledged to the President as an outcome of the Task Force on Global War on Terror Heroes that "DoD will increase attendance at TAP and Disabled Transition Assistance Program (DTAP) sessions to 85% of those separating servicemembers and demobilizing National Guard and Reserve Forces." In addition, the Department agreed to increase use of the Benefits Delivery at Discharge (BDD) Program to 85%, which will improve the efficiency at VA when supporting service-disabled veterans.

DoD Directive 1332.35, *"Transition Assistance for Military Personnel,"* assigns responsibility for policy and oversight to me. In addition, I must report to the President our progress in meeting our Global War on Terror Heroes Task Force goals, and report to the Joint Executive Committee our progress meeting DOD/VA Joint Strategic Plan goals. DoD Directive 1332.35 and DoD Instruction 1332.36, *"Preseparation Counseling for Military Personnel,"* assigns Secretaries of the Military Departments responsibility for delivering Transition Assistance Programs. In order for me to carry out my responsibilities, I must know how you plan to carry out yours. I request, therefore, that you prepare a 1/2 hour briefing for each Military Service laying out your plans. I am particularly interested in how you will apply modern technology tools to achieve our goals, improve the quality of the TAP experience, while simultaneously reducing the resource burden on our already heavily taxed leaders and staff. I will schedule the briefings for early October.

Michael L. Dominguez
Principal Deputy

cc: VADM Daniel Cooper, Under Secretary for Benefits,
Department of Veterans Affairs
Mr. Charles Ciccolella, Assistant Secretary of Veterans Employment and Training
Department of Labor

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PERSONNEL AND READINESS

FEB 11 2008

MEMORANDUM FOR ASSISTANT SECRETARY OF THE ARMY (M&RA)
ASSISTANT SECRETARY OF THE NAVY (M&RA)
ASSISTANT SECRETARY OF THE AIR FORCE (M&RA)
ARMY, G-1
CHIEF OF NAVAL PERSONNEL
DEPUTY CHIEF OF STAFF FOR PERSONNEL, AIR FORCE
CHIEF, NATIONAL GUARD BUREAU
DEPUTY COMMANDANT (M&RA), USMC

SUBJECT: Transition Assistance Program (TAP) Executive Steering Committee

This Memorandum establishes the TAP Executive Steering Committee. The establishment of this steering committee is a follow-up to the briefings you provided me in October, laying out your Service plans to increase attendance at TAP and DTAP, and to increase usage of the Benefits Delivery at Discharge (BDD) Program up to 85% for Active, Guard and Reserve Service members. During the briefings your Service was also asked to show how it would apply modern technology tools to achieve our goals and improve the quality of the TAP experience (TAB A).

At the conclusion of the briefings, I asked you to appoint a representative to serve on a TAP Executive Steering Committee (hereafter referred to as the steering committee) The steering committee's charter is to develop an overarching comprehensive plan that all Military Services, the Department of Labor (DOL), the Department of Veterans Affairs (VA), and the Department of Homeland Security will support and implement.

I have taken the liberty of identifying M&RA senior officials to serve on the steering committee with your approval. I am also requesting the Service Personnel Chiefs to identify a uniformed Service member in the grade of 06 or higher to serve on the steering committee (TAB B).

Other representatives to serve on the steering committee will come from the Assistant Secretary of Defense for Reserve Affairs, the Deputy Under Secretary of Defense for Program Integration, the Chief of the National Guard Bureau, and representatives from the DOL and VA. Assistant Secretary Ciecolella at DOL and Deputy Associate Secretary Pedigo at VA pledged their support to this effort. Ms. Leslye A. Arsht, Deputy Under Secretary of Defense for Military Community and Family Policy, will serve as the Chairperson for the steering committee.

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PERSONNEL AND READINESS

JAN 10 2008

MEMORANDUM FOR CHIEF, NATIONAL GUARD BUREAU
CHIEF, ARMY RESERVE
CHIEF, NAVY RESERVE
COMMANDER, MARINE FORCES RESERVE
DIRECTOR, AIR NATIONAL GUARD
CHIEF, AIR FORCE RESERVE
DIRECTOR, RESERVE & TRAINING, USCG

SUBJECT: Guard and Reserve Support for the Transition Assistance Program (TAP) and the Disabled Transition Assistance Program (DTAP)

As required in PL 101-510, each of us must ensure that the transition needs of our departing personnel are fully addressed. To stress the need to comply with that mandate, Secretary Gates pledged to the President, as an outcome of the Task Force on Returning Global War on Terror Heroes, that "[he] will increase attendance at TAP and DTAP sessions to 85% of those separating servicemembers and demobilizing National Guard and Reserve Forces." The Secretary further committed the Department to work with Reserve Forces commanders to explain "how important it is for all Guard and Reserve members, and their spouses, whenever possible, to attend a TAP or DTAP presentation within 30 days of their return to home units. The timeframe is important because certain benefits have specific application deadlines."

To meet additional Task Force commitments, I ask you to strongly encourage your subordinate commands and commanders or, in the case of the National Guard, the governors and the Adjutants General, to aggressively market TAP through Guard and Reserve family support networks, service organizations, and other appropriate contacts, to all National Guard and Reserve members and their families.

To assist in that effort, we developed the TurboTAP.org website, which provides Reserve Component personnel access to transition information specifically designed for their unique circumstances. Pre- and demobilizing personnel, and their spouses, by viewing the newly released Transition Guide at TurboTAP.org, can get a head start in determining the scope and depth of the many benefits for which they may be eligible. To ensure that this unfolds as efficiently as possible, we are prepared to send mobile training teams to any pre-mob and demob site, as well as to state and local National Guard and Reserve units that request assistance in training their personnel how to use TurboTAP so they can key into applicable transition benefits and support programs.

INFORMATION PAPER: TurboTAP Mobile Training Team (TTAP MTT)

Background: As part of an expanded outreach effort to members of the National Guard and Reserve who are transitioning off of active duty and returning back to their civilian communities, the Office of the Deputy Under Secretary of Defense for Military Community & Family Policy has established the TurboTAP Mobile Training Team (TTAP MTT). This traveling team consists of two or more subject matter experts who help servicemembers connect to their military benefits for life. The team also provides financial planning education, counseling services and referrals to help service and family members maximize use of those benefits. This outreach effort is a no-cost support service designed specifically for National Guard and Reserve commands. It compliments and helps integrate federal, state and local transition assistance support services.

Program Description:

- TTAP MTT uses veterans benefits and employment assistance subject matter experts and certified financial planners (or equivalents) who promote financial wellness, consumer and personal financial management education to deliver the following support services:
    - *TurboTAP Booth* -- Demonstration of the TurboTAP.org web portal, TurboTAP Accounts and Transition Assistance support services. Includes transition guides (required by law), checklists for education, employment, veterans benefits and relocation, job banks, military friendly employers, and sources of assistance at state, local and national levels.
    - *TurboTAP.org Orientation Briefings* -- TurboTAP.org briefings are tailored for specific audiences. Briefings last from 30 minutes to 1 hour. This web portal connects servicemembers to their benefits … for life!
    - *TurboTAP Accounts* -- Using local community college computer labs and mobile military computers with satellite Internet connections, the TurboTAP MTT assists servicemembers in establishing a TurboTAP account within 48 hours of learning about this valuable resource. Assistance is provided to servicemembers who want to develop an Individual Transition Plan and connect to military benefits for which they may be eligible. Servicemembers are encouraged to update their account each time their military status changes to ensure they connect with every benefit for which they may be eligible.
    - *On-demand financial planning, and consumer education and personal financial management counseling services* -- On-site financial planning

29. Senator AKAKA. Secretary Mansfield, what is VA doing to improve the transition process for the Guard and Reserve?

Secretary MANSFIELD. Increasing the number of demobilizing Guard and Reserve personnel who attend TAP and DTAP is a high priority for VA. DOD recently proposed establishing a TAP Executive Steering Committee to ensure that TAP and DTAP participation is increased to 85 percent. VA will work closely with DOD in establishing the committee to formulate plans to reach this goal.

With the activation and deployment of large numbers of Reserve/National Guard members to Afghanistan and Iraq, VA is working with DOD to expand outreach to returning Reserve/National Guard members and their families. When units of Reserves or National Guard members are returning home, VA provides briefings and assists with filing claims.

An MOA was signed in 2005 between VA and the National Guard Bureau to institutionalize this partnership and to support better communication between the two.

VA is encouraging State National Guard coalitions to improve local communication and coordination of benefits briefings to assure that National Guard and Reserve members are fully aware of benefits. In 33 States, MOUs have been signed between VA, the State National Guard offices, and the State VA to promote the relationship and cooperation to provide services and benefits to their members.

VA has an MOA with the Army Reserve in the concurrence process that will formalize this relationship as we did with the National Guard. We are also working on MOUs with the other Reserve components to formalize those relationships.

The National Guard Bureau employs 57 transition assistance advisors (TAAs) for the 50 States and four territories. Their primary function is to serve as the statewide point of contact and coordinator, providing advice to Guard members and their families on VA benefits and services and assisting in resolving problems with VA health care, benefits, and TRICARE. VA and the National Guard Bureau teamed up at the beginning of the program in February 2006 to provide training to the TAAs on VA services and benefits and help define their role as VA advocates. VA participates in annual refresher training for the TAAs, as well as the monthly TAA conference calls.

Each regional office has an OEF/OIF manager who is responsible for overseeing the OEF/OIF workload and outreach initiatives. These responsibilities include working closely with the National Guard and Reserve units to obtain service treatment records. OEF/OIF managers work with military medical facilities to ensure timely notification of casualty arrivals and to develop procedures for scheduling ward visits. Managers also work closely with Reserve/Guard Units to coordinate and provide benefits briefings.

QUESTIONS SUBMITTED BY SENATOR EVAN BAYH

HEALTH CARE FOR SERVICEMEMBERS

30. Senator BAYH. Secretaries England, Mansfield, Geren, Chu, and General Schoomaker, I've been told that one of the immediate hurdles in increasing the pool of private mental health and other medical professionals available for our soldiers outside of the DOD or VA systems is current law. As I understand, in order for psychiatrists, neurologists, or other medical professionals to provide TRICARE services, they must also accept the Medicare reimbursement. Is that the most significant hurdle we face as a Nation in providing more private health care providers to wounded soldiers or veterans?

Secretary ENGLAND and Dr. CHU. Even though we have not seen persistent access problems, in those locations where certain health care specialties are limited, we would like a larger pool of providers. To help ensure continued access to quality private sector care, our managed care support contractors have added nearly 2,800 behavioral health providers to the network since May 2007. In addition, in December 2007, we instituted a behavioral health care appointment assistance service to aid Active Duty personnel and their enrolled family members in obtaining timely mental health care.

While TRICARE's reimbursement of professional providers is based upon the methodology used by Medicare, a provider does not have to accept Medicare reimbursement in order to provide TRICARE services. A TRICARE provider has the option of becoming a network provider where negotiated discounts are expected, provide services by participating on a claim by claim basis and accepting the TRICARE payment as payment in full, or provide services as a non-participating provider and bill up to 115 percent of TRICARE maximum allowable amount.

Legislative initiatives to link the DOD and Medicare payment rates for health care began in the early 1980s and the NDAA for Fiscal Year 1996 codified the linkage to Medicare payment amounts. Based upon prior concerns involving the adequacy of TRICARE physician payment rates, a GAO review was conducted in 1998 that found that the professional provider methodology was sound and that DOD was saving about $770 million annually as a result of these maximum allowable charges. In 2001 GAO conducted another study to determine whether increases in professional payment rates would be beneficial. That report concluded that changing the

reimbursement rate would be costly, inflationary, and largely unnecessary. Due to concerns about payment rates in those localities where access was a problem, the NDAA for Fiscal Year 2001 granted new flexibility to increase TRICARE reimbursement rates in areas where access to health care services is severely impaired. The Department has implemented that authority; for example, we recently granted a waiver for child psychiatry services in Key West, FL. The Department will continue to use this authority to raise reimbursement rates where access to care is a demonstrated issue.

Secretary MANSFIELD. For eligible veterans, VA facilities are permitted to use qualified and licensed private health care providers to provide medical services through our fee basis program. VA has the ability to enter into contracts with qualified health care providers through several statutory authorities (38 U.S.C. 1703, 7409, 8153).

As a Federal health care payer, VA finds many community health care providers expect assignment of payment at Medicare rates. When VA authorizes medical care in the community, in advance of treatment, payment for professional services is generally at the 100 percent Medicare allowable reimbursement rate for most geographic areas.

VA has authority to exceed the 100 percent Medicare allowable reimbursement for services purchased in Alaska.

The reimbursement methodology and payment terms for fee-basis care are set out in VA's regulations at 38 CFR 17.55 and 17.56.

Secretary GEREN and General SCHOOMAKER. Reimbursement rates are not the most significant hurdle we face in providing more private health care providers to wounded soldiers and veterans. Title 10 requires TRICARE reimbursement, often referred to as the CHAMPUS Maximum Allowable Charge (CMAC), for civilian healthcare providers to match MEDICARE reimbursement rates. Generally, TRICARE and MEDICARE reimbursement rates are the same. This provision provides TRICARE with an industry accepted reimbursement system. Title 10 does authorize the Secretary of Defense to approve exceptions to this rule. Higher reimbursement amounts may be authorized if it is necessary to assure that covered beneficiaries retain adequate access to healthcare services. An example of this exception is the Alaska demonstration project. The Alaska demonstration project increases State-wide reimbursement rates by 35 percent across all Services. Additionally, the TRICARE Management Activity has approved other targeted rate increases in selected localities across the country.

31. Senator BAYH. Secretaries England, Mansfield, Geren, Chu, and General Schoomaker, how would you recommend to Congress that we amend this law?

Secretary ENGLAND and Dr. CHU. When access to mental health services is related to professional reimbursement rates, the Department will continue to use the existing waiver authority. Rate increases targeted to those localities where access to care is severely impaired may improve access, but will not address other problems such as scarcity of mental health providers. The law already provides the flexibility needed to increase payment rates when access to care is an issue and states that payment for services by an individual health care professional shall be equal to the amount determined to be appropriate to the extent practicable in accordance with the same reimbursement rules for services under title XVIII of the Social Security Act.

Secretary MANSFIELD. VA has yet to experience difficulty in locating providers willing to accept Medicare reimbursement for the treatment of veterans, except in the State of Alaska. However, in the State of Alaska, VA has regulatory authority to exceed the Medicare fee schedule. VA also has the authority in certain circumstances, to negotiate payment rates exceeding Medicare fee schedules with providers by contract or other legal agreement. VA does not see a need for any change in the legislation at this time.

Secretary GEREN and General SCHOOMAKER. We do not recommend amending this law. The law provides the Secretary of Defense the necessary flexibility to grant exceptions.

32. Senator BAYH. Secretaries England, Mansfield, Geren, Chu, and General Schoomaker, how would that enable you to provide better care?

Secretary ENGLAND and Dr. CHU. There may not be a direct correlation between paying more and obtaining better care. When justified, paying more to obtain needed health care services and treatment may benefit the patient under specific circumstances. We believe TRICARE already has the necessary authority to pay more, when access problems are demonstrated.

Better care is the focus of the Department's larger effort on psychological health. We have charged the new Center for Psychological Health with identifying best practices.

Secretary MANSFIELD. VA does not see a need for any change in the legislation at this time.

Secretary GEREN and General SCHOOMAKER. We do not feel the law needs to be amended.

33. Senator BAYH. Secretaries England, Mansfield, Geren, Chu, and General Schoomaker, can you please describe the extent to which non-government experts or institutions have been used in assessments of DOD and VA mental health care? If that outside input is limited, please provide the reasoning behind it. If it is not, please describe the instances when it has been used within the past 5 years.

Secretary ENGLAND and Dr. CHU. The members of the DOD Mental Health Task Force that examined the state of mental health care around the globe in DOD were civilians, with five of seven being non-governmental subject matter experts. While they identified a number of areas for potential improvement, they concluded in their final report that, "In the history of warfare, no other nation or its leadership has invested such an intensive or sophisticated effort across all echelons to support the psychological health of its military servicemembers and families as the DOD has invested during the global war on terrorism."

Subject matter experts from non-governmental academic sectors continuously collaborate with DOD clinicians, whether it be through shared research or established training programs around the country, in which civilian staff rotate to military sites and military staff rotate to civilian sites. These programs are of such rigor as to consistently result in highly competitive scores of military residents in a variety of medical specialty programs.

DOD programs, such as those in suicide prevention, are widely respected, and supported through multiple collaborations with leading world experts. Such experts are integrally involved in both formally evaluating and shaping our programs through collegial workshops and conferences. The most respected non-governmental mental health morbidity experts are involved in assessing the effectiveness of our population-based screening programs, and our online mental health screening programs are rooted in the finest non-governmental programs in existence.

Secretary MANSFIELD. The Under Secretary for Health's Committee on Care of Seriously Mentally Ill Veterans (SMI Committee) has, from its inception in the 1990s, been associated with a Consumer Liaison Council which meets in conjunction with the SMI Committee which is composed of VA mental health experts and field leaders. The Consumer Liaison Council has members from several of the mental health advocacy groups (e.g. National Alliance for the Mentally Ill), veterans service organizations (e.g. American Legion, Vietnam Veterans of America) and professional organizations (e.g. American Psychological Association). The Consumer Council hears reports from VA on progress of programs and makes comments to the SMI Committee.

VA entities such as the National Center for PTSD (NCPTSD) and the mental illness research education clinical centers all have advisory boards which are composed of VA and non-VA experts in mental health issues. For example, the Chair of the Board on the NCPTSD scientific and educational advisory boards is a non-VA expert. The advisory boards hear about progress on VA projects and make suggestions for further activities.

In addition, during the past several years, VA has contracted with RAND Corporation to carry out a comprehensive assessment of VA mental health care that is ongoing.

The outside organization with the greatest impact on assessing mental health services in the Veterans Health Administration (VHA) is the Joint Commission. Every VA medical center and clinic must receive ongoing accreditation by the Joint Commission and meet its continually updated standards.

In addition, VHA has asked the Commission on Accreditation of Rehabilitation Facilities (CARF) to review increasing numbers of mental health rehabilitation programs. VHA programs required to achieve and maintain CARF accreditation include:

a. Mental health residential rehabilitation and treatment services, which include, but are not limited to:

(1) Domiciliary residential rehabilitation and treatment programs;
(2) Psychosocial residential rehabilitation treatment programs;
(3) Substance abuse residential rehabilitation treatment programs; and
(4) PTSD residential rehabilitation treatment programs.

b. Employment and community services which include, but are not limited to:

(1) Comprehensive homeless veterans centers;
(2) Intermediate health care for homeless veterans programs with four or more fulltime employees; and
(3) Compensated work therapy, and compensated work therapy-transitional residence with four or more full-time employees combined, or incentive therapy programs with four or more full-time employees.

c. Starting in fiscal year 2008, VHA's new psychosocial rehabilitation and recovery centers and day treatment centers that transition to psychosocial rehabilitation and recovery centers will also be required to achieve CARF accreditation.

d. The recent Institute of Medicine (IOM) reports on assessment of PTSD and treatment of PTSD are examples of non-VA input. However, the task for IOM was not to evaluate VA mental health care, but to evaluate the published research literature on assessment and treatment in order to inform VA on best practices. In response to the recently released report on PTSD treatment, OMHS and the Office of Research and Development (ORD) have held a planning meeting to develop guidance on design and evaluation of clinical trials. That meeting included a number of non-VA academic experts in PTSD and research design.

Secretary GEREN and General SCHOOMAKER. The Army has used internal and external resources to review existing behavioral health service delivery and quality in both garrison and operational environments. Over the past 5 years, the Army has executed five MHAT assessments of operational behavioral health. This has resulted in significant adjustments to the deployed behavioral health footprint and has shaped deployment preparation training for uniformed behavioral health assets. MHAT recommendations also led to the establishment of the Battlemind Training System, a comprehensive training program for soldiers and family members. The latest MHAT report will be released shortly.

The Army also conducted an external review of garrison based mental health activities. Over the course of a 19-week project (October 2006 through January 2007), BearingPoint conducted a review of the Army Medical Command's (MEDCOM) Behavioral Health service line with the overall objective of assessing the effectiveness and efficiency of the system and developing recommendations to improve services. For this assessment, the research team visited 22 MTFs conducting behavioral health operations, both CONUS and OCONUS. BearingPoint implemented a comprehensive multi-method approach, seeking not only to address factual observations, such as workload and cost metrics, but also to understand how the various constituencies in each community perceive the quality and value of behavioral health services. Their research included an on-line survey for soldiers, in-depth interviews with behavioral health staff and providers, a combination of in-depth interviews and an on-line survey with military leaders, and focus group discussions with soldiers and family members. The team also reviewed each MTF's organizational structure, operations, and cost and workload data. A final report was released on February 13, 2007, and resulted in 38 key findings which were further refined to 9 actionable issues. MEDCOM has approved a pilot program to incorporate these findings.

The DOD Mental Health Task Force consisted of military, Federal, and non-Federal behavioral health experts. The Task Force's findings and recommendations have informed many of the Army's current efforts to increase access to care and decrease stigma. Finally, soldiers in every component of the Army were directed to participate in mandatory training on mild TBI and PTSD. This chain-teaching program was intended to provide leaders and soldiers information and resources on concussions, Post Combat Stress, and Operational Stress. It was developed in consultation with 11 external subject matter experts.

The Army Provider Level Satisfaction Survey (APLSS) was developed by Synovate, a third party industry leader in health care survey research who also developed the survey model used by Kaiser Permanente to measure patient satisfaction with the medical care they receive. Patient responses on the APLSS are aggregated at the individual provider level. Data are evaluated monthly and posted electronically by provider, clinic, MTF, regional medical command, and MEDCOM levels. These results are available via a password-protected Office of the Surgeon General survey website that can be accessed by MTF leadership and providers. The aggregated results are compared to a civilian benchmark which was developed by having a panel of civilian households complete the same survey.

34. Senator BAYH. Secretaries England, Mansfield, Geren, Chu, and General Schoomaker, last April, I introduced S. 1113. Included in that legislation was a plan to ensure that servicemembers who incur a covered TBI while on Active Duty be

retained on Active Duty for 1 year after the medical assessment of their ability to perform their activities of daily living. Further, the bill would have provided for the limitation of physical evaluation boards for such members for 1 year. In my legislation, these options would have been waiverable by the servicemember or their legal representative. Please comment on these proposals. How would the DOD view them? How would the VA view them?

Secretary ENGLAND and Dr. CHU. While we are learning valuable information about TBIs, and expect to learn even more with the research being funded, there is a wide range of TBI severity and there currently exists other administrative options to handle these cases in a similar fashion, such as being placed on the Temporary Duty Restriction List (TDRL), which allows for medical reassessment in a designated time. Medical assessment occurs frequently during the continuum of care in the servicemember's treatment and convalescence. Once it is determined that it is likely the servicemember will not be able to return to full duty, in a year the servicemember is entered into the Disability Evaluation System. Fitness for continued retention is not a medical decision, but rather a Service-specific determination based on the Service's mission requirements, which may be hindered by legislation of medical conditions. Until more information is gained on TBI as well as other conditions, to aid DOD in accession and retention decision-making, we are concerned that creating legislation now may not be beneficial or equitable to all servicemembers.

Secretary MANSFIELD. Legislative plan S. 1113 might be appropriate for a servicemember with milder TBI and who has a good prognosis to return to military service, ready access to early rehabilitation interventions that will identify, target, and achieve community reentry goals. VA does not support blanket retention of all military servicemembers with TBI on Active Duty for a year after medical assessment. Active Duty members who will not likely return to duty (e.g., moderate to severe head injury) have the greatest potential to benefit from comprehensive rehabilitation services that are initiated as soon as possible, together with early community re-entry rehabilitation interventions.

Retaining servicemembers on Active Duty for 1 year could be counterproductive for the patient by delaying initiation of veterans benefits or impeding their continuity of rehabilitative care management across multiple systems of care (e.g., referrals back and forth between DOD, VA, and civilian facilities).

Secretary GEREN and General SCHOOMAKER. Decisions related to retention on Active Duty are made on an individual basis by trained clinicians. A tool now available to assist clinicians with these decisions is the Clinical Management Guidance for Mild TBI in non-deployed environments. The Army developed this tool and coordinated with the Office of the Assistant Secretary of Defense for Health Affairs to have it published. The tool provides guidance in the management of servicemembers with persistent symptoms that interfere with their performance of duty.

35. Senator BAYH. General Schoomaker, the reality is that our Nation and the military's medical system face significant shortages of mental health professionals. In fact, as I understand, the Army is trying to hire 272 new mental health professionals this year. Unfortunately, the Army has estimated that it will have only 150 by March. As a result, our system today is hard-pressed and strained, at best, to provide the essential care that so many of our soldiers who suffer from TBI and PTSD need. With that in mind, should we instead be focusing our efforts on taking the needed steps to increase access to quality, community-based and private care for our wounded soldiers?

General SCHOOMAKER. To provide optimal care for our soldiers, we must make full use of the Military Health System (MHS), the VAs, and private sector care. Currently the MHS makes extensive use of private sector care through the TRICARE Network. The Office of the Assistant Secretary of Defense for Health Affairs (HA) recently issued a new policy to ensure beneficiaries have appropriate access to mental health services by aligning mental health access standards with existing primary care access standards. This policy directs two new business practices. First, military mental health clinics must provide more self-referral capabilities, much like a primary care clinic. Mental health clinics traditionally operated as specialty referral clinics with limited self-referral capabilities. Second, the policy establishes a 7-day routine standard for newly onset, non-urgent behavioral health conditions or exacerbation of a previously diagnosed condition. MTFs closely track access standards for our wounded soldiers. If access to care standards cannot be met at a military facility, the soldier is referred to the private sector for care. In addition, it is essential to partner with civilian health care providers to ensure that they have the education and training to care for our soldiers and veterans.

36. Senator BAYH. Secretary Chu, because of advances in force protection measures and field medicine, wounded servicemembers are fortunately surviving at a much higher rate than in previous wars. Unfortunately, due to the nature of the blasts causing injuries, many are left with a TBI. While still on Active Duty, wounded servicemembers can be treated for almost any ailment at MTFs, VA, or private facilities at little or no expense to the patient or family. However, once a servicemember has retired, TRICARE is limited to its legally defined coverage and does not include the cognitive therapies necessary for TBI rehabilitation. While the VA can provide TBI care in many cases, it may not be appropriate for every individual, and these injured heroes have earned the access to all available options. Do you agree that injured servicemember/veterans' care should based on their medical condition, not on their status as Active Duty or retired? If so, what are you doing to address this situation?

Dr. CHU. Injured servicemembers/veterans' care should be based on their medical condition. However, until recent changes in the law under the NDAA for Fiscal Year 2008, the DOD was statutorily limited in the Services it could cost share for members who had separated from Active Duty or retired.

Active Duty servicemembers are authorized cognitive rehabilitation services under the law. The benefits authorized in section 1631 of the NDAA for Fiscal Year 2008 allows the Secretary, through regulations, to authorize any former member of the Armed Forces with a serious injury or illness to receive the same medical and dental care as a member of the Armed Forces on Active Duty for such care not readily available in the VA.

Rehabilitation therapy covered under the TRICARE Basic Program is available to both servicemembers and retirees, and includes physician-prescribed therapy to improve, restore, or maintain function, or to minimize or prevent deterioration of patient function. Prior to the enactment of section 1631, rehabilitation therapy under the TRICARE Basic Program for members who retired, medically or otherwise, had to be medically necessary and appropriate care keeping with accepted norms for medical practice in the United States, rendered by an authorized provider, necessary to the establishment of a safe and effective maintenance program, and could not be custodial, or otherwise excluded from coverage.

Covered rehabilitation services for TBI patients may include physical, speech, occupational, and behavioral services. Cognitive rehabilitation strategies may be integrated into these components of a rehabilitation program and may be covered under the TRICARE Basic Program when cognitive rehabilitation is not billed as a distinct and separate service except for Active Duty servicemembers and those that may be covered under section 1631. For all others under the TRICARE Basic Program, cognitive rehabilitation defined as "services that are prescribed specifically and uniquely to teach compensatory methods to accomplish tasks which rely upon cognitive processes" are considered unproven and are not covered when separately billed as distinct and defined services.

For other than Active Duty servicemembers and those that may be covered under section 1631, in determining whether a medical treatment has moved from unproven to proven, TRICARE reviews reliable evidence, as defined in 32 Code of Federal Regulations Part 199. Research study of cognitive rehabilitation in neurological conditions including TBI is limited by differences between patients, and by variation in the type, frequency, duration, and focus of cognitive rehabilitation interventions. The TRICARE determination that cognitive rehabilitation for TBI is unproven is supported by a 2002 Technical Assessment performed by Blue Cross/Blue Shield (updated in 2006), and by a 2004 Technical Assessment by Hayes Incorporated also updated in 2006. Our own commissioned Technical Assessment in 2007 further supported the TRICARE determination as the literature available is inconclusive on cognitive rehabilitation therapy's role in the treatment of TBI.

Medical evidence is dynamic and evolving, however, we know that some care that is considered unproven today will in the future achieve the required evidence threshold and become covered under the TRICARE Basic Program. Care that is likely to become proven is periodically reevaluated to ensure that TRICARE coverage is current and consistent with the latest evidence.

Beneficiaries, including Active Duty servicemembers, may receive rehabilitation services in direct or purchased care facilities. Active Duty servicemembers may also receive TBI rehabilitation in specialized VA treatment centers. In most cases, patients will be referred to a rehabilitation facility that has agreed to participate in the TRICARE network. Both Active Duty and non-Active Duty beneficiaries may be referred for care in a non-network facility when there are no available network facilities able to meet the identified medical needs of the patient in the area where the patient lives or needs to receive care.

Service	Supplemental Care Program—Active Duty	TRICARE Basic Program (retired members)	Veterans Affairs
Occupational, speech, or physical therapy	Yes	Yes	Yes
Behavioral health services	Yes	Yes	Yes
Cognitive rehabilitation	Yes	Yes, if part of a comprehensive rehabilitation program and not billed as a separate service.	Yes
Vocational rehabilitation	Yes	No	Yes
Skilled nursing facilities-Prospective Payment System (SNF–PPS).	Yes	Yes, SNF–PPS methodology, no time limit	Yes
Comprehensive post-acute brain injury rehabilitation programs.	Yes	No	Yes
Community integration rehabilitation	Yes	No	Yes
Educational rehabilitation	Yes	No	Yes
Transitional living programs	Yes	No	Yes
Nursing home care	Yes	No	Yes
Home health care (skilled)	Yes	Yes, partial intermittent up to 28 hours/week	Yes
Non medical aides and attendants	Yes	No	Yes
Respite care	Yes	No	Yes
Advanced prosthetic care	Yes	Yes, if medically necessary	Yes
Driving assessment and training	Yes	No	Yes

37. Senator BAYH. Secretary Chu, can you assure me that the overlap of benefits authorized in the recent NDAA will include access to the Active Duty cognitive therapy coverage?

Dr. CHU. Clarification on Cognitive Therapy vs. Cognitive Rehabilitation:

Cognitive-Behavioral Therapy (CBT) is a form of psychotherapy emphasizing the important role of thinking in how we feel and what we do. It does not exist as a distinct therapeutic technique. The term "cognitive-behavioral" is a general term for a classification of related therapies, based on the idea that thoughts are the cause of feelings and behaviors, rather than external things, like people, situations, and events. Patients are helped to change the way they think in order to feel and act better even if the situation does not change.

CBT is covered under the TRICARE program, for both active servicemembers and retirees, as psychotherapy. Psychotherapy must be medically or psychologically necessary.

Cognitive Rehabilitation is defined as systematic goal-oriented treatment designed to improve cognitive functions and functional abilities (including memory, language, concentration, attention, perception, learning, planning, sequencing and/or judgment) which may be recommended for patients with acquired brain injury.

Active Duty servicemembers are authorized cognitive rehabilitation services under the law. The benefits authorized in section 1631 of the National Defense Authorization Act for Fiscal Year 2008 allows the Secretary through regulations to authorize any former member of the Armed Forces with a serious injury or illness to receive the same medical and dental care as a member of the Armed Forces on Active Duty for such care not readily available in the VA.

Rehabilitation therapy covered under the TRICARE Basic Program is available to both Active Duty servicemembers and retirees, and includes physician-prescribed therapy to improve, restore, or maintain function, or to minimize or prevent deterioration of patient function. Prior to the enactment of section 1631, rehabilitation therapy under the TRICARE Basic Program for members who retired, medically or otherwise, had to be medically necessary and appropriate care keeping with accepted norms for medical practice in the United States, rendered by an authorized provider, necessary to the establishment of a safe and effective maintenance program, and could not be custodial, or otherwise excluded from coverage. Covered rehabilitation services for TRICARE patients may include physical, speech, occupational, and behavioral services. Cognitive rehabilitation strategies may be integrated into these components of a rehabilitation program and may be covered under the TRICARE Basic Program when cognitive rehabilitation is not billed as a distinct and separate service. Under the TRICARE Basic Program, cognitive rehabilitation defined as "services that are prescribed specifically and uniquely to teach compensatory methods to accomplish tasks which rely upon cognitive processes" are considered unproven and are not covered when separately billed as distinct and defined services, except under the authority of section 1631. This section has a sunset provision of December 31, 2012.

In our experience, the VA health benefit is intentionally structured to provide robust care to disabled veterans with long-term rehabilitation and other care needs.

38. Senator BAYH. Secretary Chu, in her testimony before the Dole-Shalala Commission this past summer, Colonel Joyce Grissom, the medical director for TRICARE Management Activity, told Commission members that TRICARE was at work reexamining the evidence to determine "if some of the cognitive rehabilitation modalities can be brought in to the benefit for all [TRICARE] beneficiaries," and that a technical report would be provided to TRICARE officials this past August. Was this report provided to TRICARE officials, and if so, what were the results of this reexamination?

Dr. CHU. The Emergency Care Research Institute (ECRI) completed the Cognitive Rehabilitation for the Treatment of Traumatic Brain Injury report and submitted it to the Department in July 2007. ECRI Institute is an independent, nonprofit health services research agency and a Collaborating Center for Health Technology Assessment of the World Health Organization.

In its summary of findings, ECRI concluded that there was insufficient, evidence-based research available to conclude that Cognitive Rehabilitation Therapy (CRT) is beneficial in treating TBIs. The Department acknowledges that there is expert opinion recommending CRT in the treatment of TBI; however, expert opinion is the weakest support in the hierarchy of evidence used to determine coverage. The DOD will continue to look for future evidence-based research that objectively supports the efficacy of CRT in the treatment of TBI.

QUESTIONS SUBMITTED BY SENATOR MARK PRYOR

PRIVATE DOCTORS

39. Senator PRYOR. Secretary Mansfield, how many cases referred to private doctors for specialized care on a fee basis have not been paid?

Secretary MANSFIELD. VA does not track its fee claims processing by the types of specialized care. Only aggregate data is available. The most recent claims processing data available are for January 2008.

During the month of January 2008, a total of 797,247 claims were received for processing, including claims carried over from the month of December 2007. Of this total, 544,816 claims were processed and 252,431 claims remained pending at the end of the month. The number of pending claims aged greater than 30 days at the end of the month was 118,166 claims, or 14.8 percent of the total claims received.

40. Senator PRYOR. Secretary Mansfield, what is the problem?

Secretary MANSFIELD. During fiscal year 2007, VHA has placed considerable focus upon timely processing of fee claims. This includes standardized reporting to assess outliers as well as determining necessary technology needs to meet significant program growth. Identified problems in achieving improved performance include the following:

- Receipt of incomplete claims from vendors lacking sufficient supporting documentation necessary to adjudicate the claim;
- Significant growth in the use of the fee program to meet access needs; and
- Improvements in information technology necessary to enhance automation of claims processing, currently a significant portion of claims processing is manual in nature.

41. Senator PRYOR. Secretary Mansfield, what are the solutions?

Secretary MANSFIELD. The solution will combine additional staffing along with technology enhancements. During fiscal year 2008, VHA received additional funding support for this staffing requirement and facilities have been able to increase staffing levels in claims processing units to meet our targets. The President's budget includes resources that will help meet the growth in this program. An improved technology solution is being actively pursued, with a recent request to transfer dollars to the IT appropriation to meet this critical need. It is our intent to implement these changes in fiscal year 2009.

MENTAL HEALTH

42. Senator PRYOR. Secretary Geren and General Schoomaker, how are pre- and post-deployment mental health assessments being improved to adequately evaluate

a soldier returning from combat overseas for the variable and unpredictable onset of PTSD?

Secretary GEREN and General SCHOOMAKER. The Army continues to use existing medical surveillance systems to screen for a range of behavioral health issues, including PTSD. There have been no recent formal changes to the current screening process or questionnaires.

Soldiers are screened in accordance with DOD Instruction 6490.03 and the Deployment Cycle Support System. Soldiers are screened for both physical and mental/behavioral health conditions prior to deployment, upon redeployment, and within 90–180 days after redeploying. The screenings consist of a self reporting section and an interview with a health care provider. Completed screenings are reported through the Medical Protection System to the Armed Forces Health Surveillance Center (AFHSC). The AFHSC staff performs analyses on the data stored in the Defense Medical Surveillance System to identify trends. The analysis and findings will be used to improve future pre and post mental health assessment tools.

43. Senator PRYOR. Secretary Geren and General Schoomaker, what type of reintegration programs is the military pursuing that helps our wounded warriors and their families not only heal both physically and emotionally, but instill confidence in their ability to tackle the challenges of life after the military as an injured veteran?

Secretary GEREN and General SCHOOMAKER. The events of the last year have led to a strengthened partnership between the DOD and the VA. In close coordination with the VA, the Army has added 16 VA advisors at major MTFs to facilitate the process of applying for benefits and finalizing arrangements for follow-on care and services for a smooth transition to civilian status.

The Army recently partnered with the University of Kansas to create the Wounded Warrior Education Initiative which will allow participants to complete a Master's degree, then return to the Army either in Active Duty status or as a civilian. The Combined Arms Center at Fort Leavenworth, KS, will benefit from these wounded warriors' education and personal experiences. In addition, the Army is currently piloting at Fort Bragg, NC, the Warrior Transition Employment Reintegration and Training Program which enables wounded warriors, working with the staff of the Soldier Family Assistance Centers, to receive education and training on how to create a resume, network, and develop job hunting skills. Through this program, WTs are assisted by counselors from the Army Wounded Warrior Program, Veterans Affairs advisors, and the staff of the Army Career and Alumni Program to develop a winning approach to obtaining employment when they leave the Army.

Integral to the Army Medical Action Plan is the Comprehensive Care Plan (CCP). The CCP is a holistic approach to facilitate healing of the body, mind, heart, and spirit by having WTs follow the principles of being responsible for their own future, gaining more control over their lives, promoting health and a sense of well-being, maintaining a positive self identity, shaping satisfying social relationships, and overcoming social and cultural barriers. The CCP ensures attention is given to all these areas. Family members, caregivers, and others who are significant in each WT's life also play an integral role in the success WTs have in rehabilitating and becoming prepared to be productive when they are either able to return to duty or separate from service and become engaged and productive civilians.

Additionally, the Army Wounded Warrior Program (AW2) was established to assist the most severely wounded soldiers and their families, throughout their lifetimes, regardless of location. AW2 is vital in helping the wounded warrior become self-sufficient, contributing members of our communities. AW2 provides unique services to the most severely wounded and their families by:

- Helping wounded soldiers remain in the Army by educating them on their options and assisting them in the application process;
- Helping with future career plans and employment opportunities beyond their Army careers;
- Supporting them with a staff of subject matter experts proficient in non-medical benefits for wounded soldiers;
- Helping a soldier obtain full VA and Army benefits;
- Helping a soldier and their family get health care after retiring from the Army; and
- Helping a soldier get financial counseling.

Soldier Family Management Specialists located throughout the country at major MTFs and VA Medical Centers provide on the ground support to soldiers and their families from the time they arrive. Soldier Family Management Specialists act as

career and education guides, benefits advisors, military transition specialists, local resource experts, family assistants, and life coaches.

Companies have the opportunity to support those who sacrificed for our country by hiring soldiers severely wounded in the global war on terror. An important element in rebuilding the lives of severely wounded soldiers is gained through meaningful employment with companies throughout the world. AW2 links severely wounded, injured, or ill soldiers and companies together by providing personalized employment counseling and services. AW2 is vital in helping them become self-sufficient, contributing members of our communities. AW2 coordinators work closely with the Army Career and Alumni Program to connect prospective employers with AW2 soldiers seeking work.

Consistent with the objectives of the Army Medical Action Plan, the Army will continue to work with public and private entities to provide WTs the skills and assistance they require in their recovery to keep alive the "can do" attitude that characterizes these great men and women.

44. Senator PRYOR. Secretary Geren and General Schoomaker, many times soldiers do not want to admit to mental health problems. What assurances or instructions has the DOD provided to its military personnel who fear that identifying a mental health issue would adversely affect or jeopardize their careers?

Secretary GEREN and General SCHOOMAKER. It is critically important that soldiers are able to seek help without worrying about the effects on their career. Soldiers and civilians alike are traditionally concerned about jeopardizing their security clearances. The Army is working with the DOD to revise the medical question on the security clearance form and eliminate that concern. During a soldier's service it is very likely that he or she can be called to deploy to a remote location away from family for sometimes extended lengths of time. The Army has recognized that building soldier and family resiliency is key to maintaining health and welfare. We developed "Battlemind" training products to increase this resiliency and have different training programs available for pre-, during, and post-deployment. These programs are designed for soldiers and their families, including children as young as pre-school aged, and they are distributed throughout the force. These programs are also available online anytime at www.behavioralhealth.army.mil.

In a bold effort to both raise awareness and reduce the stigma associated with seeking mental health care, the Secretary of the Army and Chief of Staff of the Army initiated a leader chain teaching program to educate all soldiers and leaders about post-traumatic stress and signs and symptoms of concussive brain injury. This was intended to help us all recognize symptoms and encourage seeking treatment for these conditions. All soldiers were mandated to receive this training between July and October 2007, during which time we trained over 800,000 soldiers. We are now institutionalizing this training within our Army education and training systems to continue to share the information with our new soldiers and leaders and to continue to emphasize that these signs and symptoms are a normal reaction to a stressful situation and it is absolutely acceptable to seek assistance to cope with these issues.

Our efforts to decrease stigma appear to be having an impact. Findings from the most recent MHAT report show small but significant decreases in stigma. Rates of stigma are significantly lower in 2007 as compared to 2006 as reflected by responses to four of six survey questions related to stigma. Although we cannot draw a direct connection, this may be related to the leader chain teaching program and other Battlemind educational products.

QUESTIONS SUBMITTED BY SENATOR SAXBY CHAMBLISS

NATIONAL INSTITUTES OF HEALTH

45. Senator CHAMBLISS. Secretary Chu, 2 years ago, a research group funded by the National Institutes of Health (NIH) reported very promising results with the use of progesterone, a hormone that appears to protect damaged brain tissue, in the treatment of civilian trauma patients with moderate to severe brain injury. The NIH moved forward with a planning grant and is expected to decide in March whether it will fund a major national clinical trial of this treatment in civilian trauma centers. If the NIH moves forward with this research, would DOD want to participate?

Dr. CHU. The Department would consider offering some Military Health System sites and those of the Clinical Consortium being put in place under the Traumatic

Brain Injury Broad Area Announcement by the Congressionally Directed Medical Research Program.

46. Senator CHAMBLISS. Secretary Chu, given the slow NIH funding process, do you believe DOD should support promising treatments (either by partnering with NIH or by a parallel process) in order to accelerate their validation?

Dr. CHU. The Department partners routinely with the NIH, as well as engaging in its own extramural research program that supports early detection, diagnosis, and treatment of TBI.

47. Senator CHAMBLISS. Secretary Chu, would DOD consider providing additional funding to increase the number of civilian centers involved in testing a new treatment in order to find an answer more quickly?

Dr. CHU. The Department is using funding from the Fiscal Year 2007–2008 Supplemental Appropriations for psychological health and TBI, and is already investing in a clinical consortium to support that objective.

48. Senator CHAMBLISS. Secretary Chu, if this treatment is deemed to be promising enough by the NIH to warrant a major study to determine if it is effective, would DOD want to conduct its own study?

Dr. CHU. That should not be necessary.

49. Senator CHAMBLISS. Secretary Chu, what type of partnership between DOD and NIH is appropriate to advance this type of research?

Dr. CHU. The NIH already participates in the Department's research management process. If agreements that are more formal or transfer of funds for cooperative efforts are required, Interagency Agreements will be sufficient.

TRAUMATIC BRAIN INJURY

50. Senator CHAMBLISS. Secretary Geren and General Schoomaker, do you have the tools you need to make objective pre- and post-injury assessments of personnel with mild to moderate TBI?

Secretary GEREN and General SCHOOMAKER. The diagnosis of mild TBI, also known as concussion, relies on the clinical interview. Throughout medicine there are no current gold-standard objective tests for the diagnosis of concussion. This is a very active area of investigation.

For pre-injury assessment, in order to facilitate the evaluation and management of concussion, the Army has implemented a program to collect baseline neurocognitive data on Active and Reserve Forces prior to their deployment to combat theaters. The Automated Neuropsychological Assessment Metrics (ANAM) has thus far been performed on 40,000 soldiers predeployment. The Army has recently been funded to expand our neurocognitive assessment program to include all deploying personnel. We are actively coordinating with the Air Force, Navy, and Marines to test all deploying military personnel.

Post-injury, all assessments are used in conjunction with the clinical evaluation. The Military Acute Concussion Evaluation (MACE) is a tool to standardize the clinical evaluation of those soldiers suspected of having a concussion. The application of the ANAM in Theater will give front-line providers another critical piece of information for the evaluation and management of injured servicemembers. The ANAM does not diagnose TBI, but importantly is able to measure the unseen, subtle effects of injury. Other post-injury assessments tests for concussion, including serologic biomarkers and the Brain Acoustic Monitor, are undergoing critical and necessary evaluation as post-injury objective tests.

Moderate TBI is easier to detect since individuals have a loss of consciousness greater than 30 minutes and difficulty laying down new memories for greater than a day.

51. Senator CHAMBLISS. Secretary Geren and General Schoomaker, how much training is required for individuals to conduct these assessments?

Secretary GEREN and General SCHOOMAKER. Training is a very important aspect of making objective post-injury assessments of mild TBI. Depending on the individual's background and experience with mild TBI, the amount of training required varies. We provide training and education to our providers prior to deployment, and while in Theater, to enhance their skills in this area. We are implementing a mandatory standardized web-based TBI training program for all healthcare professionals to include clinical support personnel. Training on administration of the

ANAM is in progress for primary care providers and all deploying neuropsychologists. Additionally, we will soon be issuing guidance for implementing the revised 2008 PDHA and PDHRA forms that contain improved questions to more accurately screen for TBI.

52. Senator CHAMBLISS. Secretary Geren and General Schoomaker, how do you currently determine when a soldier or marine with a concussion or mild TBI is healthy enough to return to combat, and what technology is available to you to assist in these determinations?

Secretary GEREN and General SCHOOMAKER. The Army's policy is to ensure the safety of the soldier first. When a servicemember has a concussion, healthcare providers use the MACE to standardize the appropriate evaluation and decisionmaking for diagnosis. Theater providers use a Clinical Practice Guideline that incorporates the MACE to delineate the pathways of care for concussion. These guidelines—originally published in December 2006—have recently been updated by an in-theater TBI working group. After a concussion is diagnosed, soldiers receive appropriate step-wise care in accordance with the Theater guidelines. As an additional check to see if the servicemember has recovered completely, he or she is tested under conditions of physical activity. Furthermore, the ANAM can be utilized to provide an additional check to ensure that a servicemember does not have any undetected residual effects of concussion.

53. Senator CHAMBLISS. Secretary Geren and General Schoomaker, is it currently feasible to screen for mild TBI rapidly and accurately at MASH/CASH units in the field?

Secretary GEREN and General SCHOOMAKER. Yes, the MACE is an effective and feasible method of acute TBI evaluation. To facilitate the evaluation and management of TBI, DOD is implementing a program to collect baseline neurocognitive data on Active and Reserve component prior to their deployment to combat theaters. Over 40,000 soldiers have been assessed to date. The Army has recently been funded to expand our neurocognitive assessment program to all deploying personnel and we are actively coordinating with the Air Force, Navy, and Marines to test all deploying military personnel.

Initially, the Services will use the DOD-developed/DOD-owned ANAM tool to obtain baseline data. The ANAM is a computer-based instrument that measures reaction time, short-term memory, pattern matching, and mathematical processing. The ANAM takes approximately 15 minutes to complete and is being administered as part of the predeployment readiness processing.

The application of this instrument in Theater will give front-line providers another critical piece of information for the evaluation and management of injured servicemembers. The ANAM does not diagnose TBI, but is able to measure the unseen, subtle effects of injury. DOD's expansion of the testing process will be guided by the ANAM tool, while data is collected to validate accurate clinical decisionmaking.

The Defense Health Board is establishing a scientific advisory subcommittee to perform an ongoing review of the DOD neurocognitive assessment program.

54. Senator CHAMBLISS. Secretary Geren and General Schoomaker, have you evaluated novel assessment devices (e.g. DETECT) and would you be interested in validating and testing these new technologies?

Secretary GEREN and General SCHOOMAKER. Yes, the Theater Medical Information Program is conducting an analysis of neurocognitive assessment tool alternatives. Also, the Defense and Veterans Brain Injury Center is planning a head-to-head evaluation of similar tools.

55. Senator CHAMBLISS. Secretaries Mansfield, Geren, Chu, and General Schoomaker, are you satisfied with the technology available to treat and diagnose TBI?

Secretary MANSFIELD. I am satisfied that VA is leveraging the most advanced technologies and medical practices available to diagnose and treat veterans and servicemembers with TBI. Over the past 2 years, VA has provided more than $33 million to facilities across its polytrauma system of care for state-of-the-science technology and equipment, to provide the greatest potential for rehabilitation and recovery to injured veterans and Active Duty servicemembers. Additionally, the VA polytrauma tele-health network (PTN) provides a reliable and easily accessible tool to further coordinate and manage care.

In fiscal year 2007, the PTN was expanded to include all polytrauma rehabilitation centers (PRC), polytrauma network sites, and several DOD MTFs. This ensures

that the highest level of expertise for TBI available at the PRCs is readily accessible at locations nearer the veteran's home, through this state-of-the-art video-conferencing network.

VA is leading this effort through its robust research and development programs, and will continue to integrate technology in its health care system as it emerges.

Secretary GEREN and General SCHOOMAKER. We always seek to improve our health care and expect current research in TBI enabled by investment inside and outside government will help us improve our ability to diagnose and care for TBI. For moderate, severe, and penetrating TBI there are many technological advances in treatment and the Army is adding several neurosurgical care tools to the inventory. For mild TBI (mTBI) or concussion, military medicine is actively seeking answers to the diagnostic and therapeutic challenges. We, along with the VA and civilian medical systems, still have much to learn about the nature of the injury, objective tests, and optimal treatment of mTBI/concussion. Our medical professionals collaborate and partner with the Defense and Veterans Brain Injury Center and the DOD Medical Research Program for the prevention, mitigation, and treatment of blast injury, including mTBI/PTSD. There are several initiatives underway, to include an automated medication management tool, a web portal, and tele-medicine and tele-rehabilitation tools. Throughout this effort, we have received extraordinary support from the entire Army, the senior leadership of the DOD and the VA, as well as Congress. Together we are improving the way we protect our soldiers and the way we treat and rehabilitate injured warriors.

The funds Congress provided will allow the Army Medical Department to research, develop, plan, and execute initiatives relevant to providing our patients and their families the highest quality and highest value of psychological healthcare and concussive injury treatment. We will continue to identify worthwhile investments to address the needs and gaps in care as we continue to focus on serving our soldiers and their families.

Dr. CHU. The DOD continues to advance current technology in the prevention, detection, and management of TBIs through a robust research and development program. DOD has made gains since the start of the war in developing instruments and algorithms to assist in detection and management, but there is room for further improvement as we learn more about TBI sustained in an austere environment. We hope to continue the many collaborations we have with the academic and civilian community to determine where technology can further improve our assessment and management of TBI.

56. Senator CHAMBLISS. Secretaries Mansfield, Geren, Chu, and General Schoomaker, what are your acquisition and research priorities in this area?

Secretary MANSFIELD. As TBI has emerged as a leading injury among U.S. Forces serving in military operations in Afghanistan and Iraq, VA's Office of Research and Development has adapted its existing neuroscience, trauma, and rehabilitative portfolios to the setting of polytrauma. VA-sponsored TBI and neurotrauma research priorities include projects aimed at the pathogenesis of injury, epidemiology (incidence and prevalence), cognitive and behavioral consequences, and the best means of treatment. The spectrum of VA-funded projects aligns itself with the characteristics of mild, moderate, and severe TBI. A challenging research priority has been that of augmenting the post-deployment health questionnaire through improved tools that reliably diagnose TBI. In the case of mild TBI, physical symptoms such as headache or dizziness, emotional symptoms such as anxiety or irritability, cognitive deficits such as difficulty concentrating and even sleep disturbances, have provided clues that VA researchers are exploring in an attempt to refine screening instruments. Examples include:

- The Cognition and Stroke Risk Project: Gender and Cognitive Decline (Brockton, NA)
- Functional Anatomy of Rapid Eye Movement Sleep, Brainstem Control (Dallas, TX)
- Examining the Effectiveness of Cognitive Rehabilitation in Veterans with Early Dementia and TBI (Decatur, GA)
- Demand Sensitive Rehabilitation for Executive Dysfunction (Durham, NC)
- Attentional Disorders in Patients with Brain Injury (Sacramento, CA)
- Diagnosing Combat-Related Mild TBI Using Magnetoencephalography (San Diego, CA)
- Hypothalamic and Basal Forebrain Regulation of Sleep and Arousal (Sepulveda, CA)

Other VA-sponsored research seeks an improved understanding of neuroplasticity that may suggest improved pharmacologic as well as physical means of altering TBI outcomes. An emerging area of emphasis is that that of regenerative medicine which includes using somatic stem cell approaches to replace damaged neurons, and various approaches to stimulate axonal regrowth. Examples include:

- Regulation of Neuroglial Injury and Regeneration (Ann Arbor, MI)
- Brain From Blood: Bone Marrow Derived Neurons Induced by Stroke (Augusta, GA)
- Magnetic Resonance (MR) Tracking of Stem Cells for Replacement Therapy in Amyotrophic Lateral Sclerosis (ALS) (Baltimore, MD)
- Multimechanistic Spinal Cord Repair: Role of Stem Cells and Scaffold (Brockton, MA)
- Central Nervous System (CNS) Plasticity Induced by Motor Learning Technologies following Stroke (Cleveland, OH)
- Plasticity of Micturition-Related Neurons Following Spinal Cord Injury (SCI) (Durham, NC)
- Grafting Neural Stem Cells for SCI: Analysis of Allodynia (Milwaukee, WI)
- Plasticity-Based Motor Recovery after SCI (Philadelphia, PA)
- Axonal Regeneration in the Chronically Injured Spinal Cord (San Diego, CA)

Still other arms of the portfolio aim to improve outcomes by studying PTSD occurring so commonly among veterans affected by TBI. Visual and auditory changes have suggested additional research projects useful in understanding cranial nerve-mediated changes. Examples include:

- Center for Innovative Visual Rehabilitation (Boston, MA)
- Artificial Silicon Retinal (ASR) Retinal Prosthesis Efficacy Evaluation (Decatur, GA)
- Early Detection of Noise-Induced Hearing Loss (Loma Linda, CA)
- Preventing Jet Fuel and Noise-Induced Hearing Loss (Loma Linda, CA)
- Auditory and Vestibular Dysfunction Research Enhancement Award Program (Mountain Home, TN)
- Cognitive-Behavioral Treatments for PTSD Sleep Disturbance (Philadelphia, PA)
- Development of Clinical Instrumentation for Tinnitus Measurement (Portland, OR)
- Cerebrospinal Fluid (CSF) and Plasma Pro-Inflammatory Cytokines: Relationship to Combat Exposure, PTSD and Health Status (San Diego, CA)
- Basic Mechanisms in Hearing Loss of Cochlear Origin (San Diego, CA)
- A Biological Interface for Cochlear Implants in Auditory Rehabilitation (San Diego, CA)
- Progressive Intervention Program for Tinnitus Management (Tampa, FL)

In addition to the above projects, VA will initiate in fiscal year 2008 a multi-site observational cohort study titled Neuropsychological and Mental Health Outcomes of OIF: A Longitudinal Cohort Study to examine war-related mental health dysfunction. The study will collect long-term follow-up data 3–5 years after military personnel return from their initial deployment to Iraq. The study will also determine the prevalence and course of PTSD among OIF veterans and assess the persistence of previously observed neuropsychological changes (in attention, verbal learning, visual memory, and reaction time) following war-zone participation. TBI will be examined as a possible risk factor for PTSD.

Veterans suffering from moderate to severe TBI may benefit from a more applied series of rehabilitation research projects that examine veterans' reintegration into home and family, school and work, and a broader community. Other VA research priorities include the use of biomedical engineering or assistive devices that improve treatment and rehabilitation. Examples include:

- Pathways to Vocational Rehabilitation: Enhancing Entry and Retention (Bedford, MA)
- A SCI Vocational Support Program: Implementation and Outcomes (Cleveland, OH; Dallas, TX; and San Diego, CA)
- Rehabilitation Outcomes Research Center for Veterans with CNS Damage (Gainesville, FL)

Secretary GEREN and General SCHOOMAKER. The Army core research program is currently focused on diagnostics using biomarkers in the blood to help identify the level of physical injury to the brain and on the development of neuroprotection

drugs to limit the amount of subsequent damage to the brain tissue if they are administered early after the injury.

The Fiscal Year 2007 Supplemental funded-PTSD/TBI Research Program supports basic and clinically oriented research that will: (1) result in substantial improvements over today's approach to the treatment and clinical management of TBI, including diagnostics, (2) facilitate the development of novel preventive measures, and (3) enhance the quality of life of persons with TBI. Congress mandated that the Program be administered according to the highly-effective U.S. Army Medical Research and Materiel Command two-tier review process that includes both external scientific (peer) review, conducted by an external panel of expert scientists and programmatic review. Programmatic review is conducted by a Joint Program Integration Panel (JPIP), which consists of representatives from the Departments of Defense, Veterans Affairs, and Health and Human Services. The JPIP identified several gaps in TBI research including: (1) treatment and clinical management, (2) neuroprotection and repair strategies, (3) rehabilitation/reintegration strategies, (4) field epidemiology, and (5) physics of blast. Research proposals that address these gaps will have the highest priority in funding.

Dr. CHU. There are priorities that are developed by consensus via the Tri-Service Joint Integration Program Panel hosted at the Army Medical Research and Materiel Command that will inform acquisition. There are priorities within the areas of prevention, detection, and management that may impact acquisition. Prevention priorities include primary prevention with a focused program on helmet protection that will span the spectrum from impact concussive injury to ballistic and blast injury using novel helmet design and composite materials such as cushioned pads for impact injury and nano-fibers for ballistic and blast mitigation. Detection and management priorities include evaluation of the optimal cognitive assessment instrument through a head-to-head analysis of the five leading products that will best inform acquisition. There continues to be treatment trials using a variety of modalities, techniques, and devices that will further inform acquisition decisions. Other priorities include the study of long-term sequela of TBI as evidenced by the congressionally-mandated 15-year study. There has also been identified a need to better understand the cumulative effects of repeat concussions.

57. Senator CHAMBLISS. Secretaries Mansfield, Geren, Chu, and General Schoomaker, what new basic research funding are DOD and the VA budgeting or planning for in developing new, more effective treatments for TBI?

Secretary MANSFIELD. In fiscal year 2007, VA's Office of Research and Development supported over $43 million of research aimed at developing new, more effective treatments for the broad area of neurotrauma, including TBI, spinal cord trauma, neural regeneration, and associated sensory disorders. VA estimates funding a similar amount this fiscal year. However, because VA may still fund additional projects this fiscal year, total funding for fiscal year 2008 is not available until after the close of the fiscal year.

To advance the treatment and rehabilitation of soldiers returning with these types of injuries, VA issued a request for research proposals that focus on TBI; cervical spinal cord injury; co-morbid conditions such as PTSD and trauma to extremities; screening and diagnostic tools related to mild TBI; and continuity of care between DOD and VA.

Many exciting projects have emerged from this solicitation and other funding mechanisms to help veterans suffering from mild to severe TBI, including: (1) studying neural repair after brain injury to build a better understanding of cognitive rehabilitation, as well as find potential targets for practical treatments that enhance quality of life; (2) developing a project exploring community reintegration for servicemembers with TBI (to promote seamless transition between servicemembers currently being treated, or who will one day be treated, in both DOD and VA medical facilities); and (3) several studies assessing the relationship between TBI and PTSD and their impact on health outcomes.

In addition, several VA scientists with expertise in neuroimaging and neuropsychology are turning their efforts to further understanding the brain changes that occur in TBI. This is important because following TBI there may be subtle, yet distinct, brain damage that results in memory, attention, thinking and personality changes that are difficult to diagnose and treat with current knowledge. A new study will start this year combining state-of-the-art imaging techniques (e.g., three-dimensional brain imaging and diffusion tensor imaging to examine white matter changes) with comprehensive neuropsychological assessments to fully characterize patients with TBI compared to other types of brain damage such as stroke. Knowledge from this study will help inform rehabilitation and diagnostic strategies.

Further, VA has established a polytrauma and blast-related injury quality enhancement research initiative (PT/BRI QUERI) coordinating center to promote the successful rehabilitation, psychological adjustment, and community reintegration of veterans suffering from complex, multiple injuries. Two priorities have been identified: (1) TBI with polytrauma, and (2) traumatic amputation with polytrauma. The PT/BRI QUERI is working closely with VA polytrauma rehabilitation centers to identify needs and gaps in care, as well as best practices. VA also recently issued a special solicitation for research projects on the long-term care and management of veterans with polytrauma, blast-related injuries, and/or TBI.

Secretary GEREN and General SCHOOMAKER. The DOD Blast Injury Research Program has identified DOD basic research programs ($9 million) for the Army and basic research unfunded requirements ($99.6 million) from the Army and Navy, and the Defense Veterans Brain Injury Center for fiscal year 2008–fiscal year 2015 that address the Treatment and Clinical Management gap areas identified by the Joint Program Integration Panel which was convened in response to the fiscal year 2007 war supplemental funding. These unfunded requirements will be identified in a future Program Objective Memorandum request.

Additionally, through the fiscal year 2007 war supplemental, PTSD/TBI Research Program is offering competitive funding for a Clinical Consortium, which will combine the efforts of the Nation's leading investigators to bring to market novel treatments or interventions that will ultimately decrease the impact of military-relevant PTSD and TBI within the DOD and the VA. Further, the Clinical Consortium is required to integrate with the DOD Center of Excellence (DCoE) for PTSD and TBI, which supports the DCoE's expediting the fielding of PTSD and TBI treatments and interventions. Several other award mechanisms offered by the PTSD/TBI Research Program will also support preclinical and clinical trials for more effective treatments for TBI.

Dr. CHU. The DOD is completing the award process for $150 million authorized by Congress for TBI research. The allocations will include prevention, surveillance, and approaches to both basic science examining etiologies and mechanisms of TBI and diverse clinical treatments that include virtual reality, pharmacology, rehabilitation, and cognitive retraining. The listing of detailed grants funding will be available from the congressionally-directed Medical Research Program office following final approval.

58. Senator CHAMBLISS. Secretaries Mansfield, Geren, Chu, and General Schoomaker, what new basic research funding are DOD and the VA budgeting or planning for in developing treatments for the chronic treatment of TBI that may aid in neuroregeneration, as opposed to acute treatments for the earliest stages of the injury process?

Secretary MANSFIELD. VA has established a PT/BRI QUERI coordinating center to promote the successful rehabilitation, psychological adjustment, and community reintegration of veterans suffering from complex, multiple injuries. Two priorities have been identified: (1) TBI with polytrauma, and (2) traumatic amputation with polytrauma. The PT/BRI QUERI is working closely with VA polytrauma rehabilitation centers to identify needs and gaps in care, as well as best practices.

VA also recently issued a special solicitation for research projects on the long-term care and management of veterans with polytrauma, blast-related injuries and/or TBI.

In addition, VA plans to expand its research efforts in regenerative medicine, using state-of-the-art techniques including cell and gene therapies, bioengineering and biomaterials, and molecular therapeutic agents. Molecular therapeutic agents may include, but not limited to enhancing the body's intrinsic repair mechanisms, as well as to replace damaged cells and tissues.

In fiscal year 2007, VA's Office of Research and Development supported over $43 million of research aimed at developing new, more effective treatments for the broad area of neurotrauma, including TBI, spinal cord trauma, neural regeneration and associated sensory disorders. VA estimates funding a similar amount this fiscal year. However, because VA may still fund additional projects this fiscal year, total funding for fiscal year 2008 is not available until after the close of the fiscal year. Some exciting work in this area sponsored by VA includes:

- Delivery of Therapeutic Proteins to the CNS (Baltimore, MD)
- Help-seeking Behavior and Participation in Visual Impairment Rehabilitation (Decatur, GA)
- Home-Based Tele-Health Stroke Care: A Randomized Trial for Veterans (Decatur, GA)
- Diagnosing Combat-related Mild TBI using Magnetoencephalography (San Diego, CA)

• Cognitive-Behavioral Treatments for PTSD Sleep Disturbance (Philadelphia, PA)
• Clinical Translational Strategies for Neurological Recovery (West Haven, CT)

Secretary GEREN and General SCHOOMAKER. Research for long-term chronic care is not a core military research, development, test, and evaluation (RDT&E) funded program and therefore DOD has no new basic research funding currently planned or programmed specifically for chronic TBI treatment that may aid in neuroregeneration. The core military RDT&E combat casualty care research mission for TBI is focused on neuro-protection and acute treatment for the early stages of injury to prevent or minimize the level of injury. Within the planned military core research areas for neuro-protection and extremity tissue regeneration, new technologies and biologic mechanisms may be discovered that may lend to the future work in neuroregeneration.

The fiscal year 2007 supplemental funded-PTSD/TBI Research Program does have a component with a focus on neuro-protection and repair strategies. There are 17 proposals focused on neuro-protection and repair strategies competing for the $63 million TBI research funds for which funding recommendations will be made in early March.

Dr. CHU. The Department plans to develop at least one regenerative center utilizing the latest technology in autologous stem cell research. In addition, the Defense Center of Excellence for Psychological Health and Traumatic Brain Injury is interacting with Stem Cell Incorporated, a company that has developed hormonal stimulation techniques for endogenous neural stem cells in stroke using Food and Drug Administration approved drugs. The direct transfer of such technology to TBIs may require more preclinical data but it is possible that such an approach could then be fast-tracked into a randomized clinical trial. The Defense and Veterans Brain Injury Center network would be the ideal environment and context in which to develop such a trial.

59. Senator CHAMBLISS. Secretaries Mansfield, Geren, Chu, and General Schoomaker, what new basic research funding are DOD and the VA budgeting or planning for in pre-clinical research into TBI treatments in the acute or chronic stages of the disease?

Secretary MANSFIELD. In fiscal year 2007, VA's Office of Research and Development supported over $43 million of research aimed at developing new, more effective treatments for the broad area of neurotrauma, including TBI, spinal cord trauma, neural regeneration and associated sensory disorders. VA estimates funding a similar amount this fiscal year. However, because VA may still fund additional projects this fiscal year, total funding for fiscal year 2008 is not available until after the close of the fiscal year.

Some exciting work in this area sponsored by VA includes:

• Neural Transplantation of Cultured Human-Derived Cells in Stroke (Augusta, GA)
• Schwann Cell Influence on Pathway Reinnervation (Durham, NC)
• Nogo-A Blockade and Functional Recovery after Stroke in the Aged (Hines, IL)
• Templated Scaffolds for Spinal Cord Regeneration (San Diego, CA)
• Investigation of Rehabilitation-Induced Plasticity in Brain Networks (San Francisco, CA)

Secretary GEREN and General SCHOOMAKER. The DOD Blast Injury Research Program has identified DOD pre-clinical programs ($23.8 million) and unfunded requirements ($9.5 million) for the Army in fiscal years 2008–2015.

The DOD's investment strategy for the fiscal year 2007 war supplemental appropriation (TBI $150 million) included multiple Intramural (DOD and VA) and Extramural award mechanisms focused primarily on pre-clinical TBI research. The funding mechanisms include the Concept award, which supports the exploration of a new idea or innovative concept that could give rise to a testable hypothesis; the Investigator-Initiated Research award which supports basic and clinically oriented research; the Advanced Technology-Therapeutic Development Award, which supports demonstration studies of pharmaceuticals (drugs, biologics, and vaccines) and medical devices in preclinical systems and/or the testing of therapeutics and devices in clinical studies; the New Investigator award, which supports bringing new researchers into the field of TBI; and the Multidisciplinary Research Consortium Award is intended to optimize research and accelerate the solution of a major overarching problem in TBI research within an integrated consortium of the most highly-qualified investigators.

Dr. CHU. Both the Defense Center of Excellence for Psychological Health and Traumatic Brain Injury and the Armed Forces Institute of Pathology have collaborated to develop a Biophysics Traumatic Brain Injury Laboratory which will focus on pre-clinical investigations to include development and testing. Further indications of pre-clinical priorities can be found in the Broad Agency Announcement of the congressionally-directed Medical Research Program project being managed by the Army Medical Research and Materiel Command (MRMC). The final round of MRMC programmatic review for funding is being completed this week. The funded research includes extensive funding for protocols involving pre-clinical research into treatments for both acute and chronic TBI.

QUESTIONS SUBMITTED BY SENATOR ROGER WICKER

MEDICAL RECORDS

60. Senator WICKER. Secretary England and Secretary Mansfield, I appreciate the progress the two Departments have made in sharing health information. I am frustrated that what you have described still seems to be a patchwork of link-ups between legacy systems. What progress has been made and what obstacles are there to developing a personal, portable electronic medical record for members and veterans?

Secretary ENGLAND. Leveraging existing complex clinical systems and in-place infrastructure has allowed the DOD and the VA to make significant strides in information sharing over the past several years. At the same time, we have taken advantage of the support that Congress has provided through the direction to establish a Joint Incentive Fund and the authorization to initiate pilot projects under the National Defense Authorization Act.

This strategy has allowed us to share clinically useful information more quickly. It has also provided us with a better understanding of how best to proceed in our broader, more mature DOD/VA enterprise-level information sharing efforts.

Currently, we are developing a Joint DOD/VA Information Interoperability Plan as a roadmap to better integrate our approach to implementing information sharing. The basis for our sharing of information requires an agreement on what data elements need to be shared and, for each, the level of interoperability. The ability for a clinician to be able to view a particular piece of information is obviously valuable. However, for some purposes, significant additional value can be derived if the data elements can be shared in such a way to enable computer assisted decisionmaking or computation.

While we believe that we have optimized information sharing from our existing legacy systems, we also believe more can be done to add greater long-term value to the clinicians and servicemembers, veterans, and their families. The interoperability plan will guide us in prioritizing our sharing efforts and determining how best to address the development and/or procurement of new software applications and information technology systems jointly. Approaching these broader initiatives jointly helps to ensure that we will be able to more easily share information between the clinicians in our two Departments.

The DOD/VA inpatient electronic health record initiative builds on the lessons learned and successes from legacy system data sharing, and is a prime example of how we are moving towards greater and greater interoperability. The feasibility assessment was completed. We are now in the process of assessing alternative technical approaches. This assessment will result in the selection of a technical approach in the fall of this year.

Further, DOD and VA are jointly working to develop network trusted partnership which will allow the Departments to securely share data seamlessly across our communication infrastructures. Additional communication gateways are planned to allow for the increased volume of data sharing and provide redundancy. This infrastructure enhancement will serve as the backbone for implementation of many of the initiatives highlighted in the Dole/Shalala report.

A personal, portable electronic medical record will draw information from the clinical information repositories, potentially from both DOD and VA sources. Some of that data will be from legacy systems, bringing with it the challenges inherent in working with the older technology. The implementation of newer technologies will address many of those challenges. The trusted partnership will address current challenges and any need for linkages to systems across DOD and VA.

In December 2007, DOD initiated a proof of concept project to provide beneficiaries who have common access card access to a subset of data drawn from the DOD electronic health record, AHLTA. That data set includes the ability for the

beneficiary to view allergy information, demographic information (name, social security number, date of birth, gender, marital status, race, religion, contact information, eligibility and enrollment data, and other health insurance). It also allows the beneficiary to view their medication profile including medication information from MTFs, civilian pharmacies, TRICARE Mail Order Pharmacy (TMOP), VA, and over the counter medications.

The next phase of the DOD personal health record (PHR) project will allow the beneficiary to view nonsensitive chemistry and hematology lab results, and encounter notes (nonmental health). It will also enable beneficiaries to self enter information into a personal health journal. Initially this will be health history and health trackers. During phase II, options will be explored to enable PHR access for those who do not have Common Access Cards.

Further development will continue to expand the scope of the PHR and extend it to all beneficiaries.

Secretary MANSFIELD. VA and DOD are working together to address challenges related to VA obtaining access to DOD data. Despite these challenges, VA and DOD are now sharing unprecedented amounts of electronic medical data. Over the past several years, VA and DOD have worked to develop incremental data exchange, which now support the one way and bi-directional exchange of most health data that are available in electronic format. VA and DOD continue to collaborate in developing innovative methods of sharing data between one another. Some examples of these efforts include:

1. Bi-directional exchange of data. In order to better support VA/DOD interoperability, particularly in the global war on terror efforts, both organizations are emphasizing bi-directional information exchange as a central requirement. Data from areas such as pharmacy, allergy, laboratory, and radiology are currently exchanged in a textual format for full data sharing. This information exchange means that a veteran's record becomes immediately more comprehensive and more portable.

Taking this exchange one step further, both VA and DOD are working toward establishing data exchange that are both fully bi-directional, as well as computable, which means the data can be leveraged by both systems' electronic decision support tools. Examples of VA/DOD data sharing efforts include both bi-directional health information exchange (BHIE) and clinical health data repository (CHDR), details of which include:

a. BHIE. Deployed to all VA facilities in October 2004.

b. CHDR. Shares computable health record data elements between DOD's clinical data repository (CDR) and VA's health data repository (HDR). Data are exchanged for patients identified and matched as active dual consumers (ADC) of both VA and DOD health care. VA and DOD conducted the first successful test of CHDR in a live patient environment in June 2006, and expanded to seven locations between DOD and VA. The key feature of CHDR is the exchange of standardized, computable (as opposed to textual) data. CHDR currently exchange pharmacy and allergy data elements. In April 2007, VA released remote data interoperability (RDI), which extended the existing local drug-drug and drug-allergy order checks, to include data from all VA and DOD facilities, at which a patient was treated. This ensures electronic decision support tools are based on all available electronic patient health information.

2. Global War on Terror. The "Big 7" projects are developed to facilitate a smooth transition between DOD and VA for global war on terror veterans and expedite transfer and improve management of polytrauma and TBI patients. The "Big 7" include:

a. OEF/OIF combat veteran identifier

b. TBI database which supports tracking, care quality monitoring, trend analysis, and performance improvement

c. Polytrauma marker

i. Addresses special needs of polytrauma patients

ii. Provides alerts and reminders and supports consistent management, reporting and displaying of important patient characteristics

d. DOD/VA BHIE-CDR (theater) interface provides an interface to OEF/OIF theater data in DOD's theater medical data system (TMDS) using BHIE framework

e. Joint patient tracking application (JPTA)/veterans tracking application (VTA)

i. Gives VA providers access to critical demographic and patient health information from the theater of operations in DOD's JPTA system

ii. Establishes a link in VA's VistAWeb and the CPRS tools menu

f. Clinical transfer form acts as nursing patient transfer document providing patients situation, background, assessment, and recommendations

g. DOD scanning interface attaches scanned DOD patient records to clinical document notes accessible across VA

In March 2008 we completed three data sharing initiatives (1) inpatient consults, (2) operative reports, and (3) establishing plans for the movement of medical images.

3. National Health Information Network (NHIN): Led by Health and Human Services, the VA and DOD both participate in the establishment of the NHIN. The NHIN is intended to provide a secure, nationwide, interoperable health information infrastructure that will connect providers, consumers, and others involved in supporting health and health care. The NHIN will enable health information to follow the consumer, be available for clinical decisionmaking, and support appropriate use of healthcare information beyond direct patient care so as to improve health. The Office of the National Coordinator for Health IT has invited a Federal Consortium of 26 agencies, including VA, DOD, HIS, and SSA to participate in the NHIN fiscal year 2008 trial implementation and fiscal year 2009 production deployment. The Health Information Technology Sharing (HITS) Program and Software Engineering and Integration (SE&I) architects are engaged in the fiscal year 2009 objective to demonstrate patient data exchange among selected agencies in a production environment based on the standards specifications from Integrating the Healthcare Enterprise (IHE) and the Health Information Technology Standards Panel (HITSP). Implementation of this project will support sharing of standards-based electronic patient health information with private and Federal health care providers.

Future Plans. In light of the global war on terror efforts and other existing VA/DOD information exchange programs, the two organizations have a number of plans for future efforts. The table below provides timelines regarding detailed information sharing milestones, and the list following the table, provides insight into additional efforts.

Data Sharing Initiatives	Target Completion (by the end of)
Vital signs	June 2008
Joint inpatient phase 2 analysis - technical feasibility	July 2008
Family history	September 2008
Questionnaires and forms	September 2008
Other history	September 2008
Social history	September 2008
Bidirectional health information exchange - VA–DOD imaging	September 2008

1. Continue to support one-way and bi-directional exchange with existing domains of textual data through BHIE (laboratory, pharmacy, radiology, and allergy) and FHIE.

2. Enhance BHIE to exchange medical images and scanned documents.

3. Expand the use of CHDR for exchange of computable electronic health record data to other appropriate and agreed-upon domains.

4. Automate marking of active dual consumers.

5. Enhance RDI to include additional CHDR data elements in electronic decision support as they become available.

Challenges: The issues which the implementation of VA/DOD interoperability projects face centered around the difficulty both VA and DOD staff have encountered in maintaining a solid operating status in the production environment of the current system. While the HHS-led NHIN effort could be considered a long-term strategy for interoperability, it is not yet mature. In working on this and the other interoperability solutions, neither agency foresaw the level of resource allocation, necessary to preserve the production linkage, and pinpointing the exact sources of the issues has proven difficult. Additionally, these projects are largely based upon the future HealtheVet/common services environment. Because not all components of this infrastructure are as yet in place and mature, the development staff on the project sometimes must engineer alternate solutions, slowing progress on overall system development. Finally, the mediation of standards between agencies presents some management challenges.

LEGAL ASSISTANCE

61. Senator WICKER. Secretary Geren, during our examination of Walter Reed and our military healthcare process, I was troubled to learn of the many soldiers waiting for legal assistance during the Physical Evaluation Board (PEB)/Medical Evaluation Board (MEB) process. In some cases, soldiers hired their own attorneys at personal expense because of the tremendous backlogs. As a former member of the House Appropriations Defense Subcommittee, I offered an amendment that was accepted into last year's supplemental appropriation that would implement the recommendations of the Army Inspector General to provide trained military attorneys dedicated to representing soldiers who are pursuing claims before evaluation boards. What obstacles lay in the way of recruiting and retaining staff, case managers, advocates, and legal staff?

Secretary GEREN. Recruiting and retaining case managers, advocates, and legal staff can be challenging, particularly in some of the rural areas where our WTUs are located. Despite these challenges, our WTUs were staffed at about a 90 percent staffing level on February 6, 2008. We have used a combination of civilian hires and military personnel from the Active and Reserve components in order to achieve this level of staffing.

The Army has demonstrated its commitment to provide soldiers and families the legal advocacy and assistance they require by specifically addressing this important support in the Army Medical Action Plan. The Army mobilized 18 Reserve component lawyers and legal assistants to provide legal counsel and advocacy for soldiers going through the Army Physical Disability System process. We are also pursuing a plan to expand this program by providing a lawyer and a paralegal at every Warrior Transition Battalion.

The Army is greatly appreciative of the assistance Congress provided in the Fiscal Year 2007 Supplemental Appropriations Act and the National Defense Authorization Act for 2008. The expanded hiring authorities in these Acts will help DOD attract and hire needed healthcare professionals. We have hired 138 mental health professionals with the intent to hire a total of 274.

[Whereupon, at 12:04 p.m. the committee adjourned.]